



Aspirus Health Plan, Inc.
1900 Westwood Drive
Wausau, WI 54401

Aspirus Health Plan Easy Compare Silver and Rx Copay CSR 87 Autograph INDIVIDUAL CONTRACT

This is *your contract* while *you* are covered through the Minnesota Insurance Marketplace (MNsure). It explains *your* rights and benefits under this *contract*. This *contract* is a legal contract between *you* and *us*. All coverage under this *contract* begins at 12:01 AM Central Time.

This *contract* along with any amendments and *your* application constitutes the entire agreement under which payments are made. *We* will pay the benefits set forth in this *contract*. Benefit payment is governed by all the terms, conditions, and limitations of this *contract*. This *contract* may be amended in accordance with state and federal law. Notice will be provided at least 30 calendar days in advance of any amendment taking effect except where earlier effective date is required under state or federal law. Any such amendment will not affect a claim starting before the amendment takes effect. This *contract* has been issued and delivered to *you* in Minnesota. Except as otherwise stated in this *contract*, this *contract* will be governed by federal law and the laws of Minnesota.

This *contract* was issued on the basis that the information on *your* application or otherwise provided as part of your enrollment process was correct and complete. If any of this information provided was not correct, write to *us* within ten calendar days of receipt of this *contract*. An error or omission on *your* application or in *your* enrollment process, as applicable, may cause *us* to ask *you* to pay an increased *premium*. If *you* misstate *your* age or make other unintentional errors, *we* will refund overpayments or collect the balance due based on *your* correct age. *We* can rescind *your* coverage for intentional misrepresentation or fraud. After *your* coverage under this *contract* is validly in effect, its validity cannot be contested unless *you* (or anyone seeking coverage on *your* or *your dependent's* behalf, including a personal representative) performed an act, practice, or omission that constitutes fraud, or *you* or *your dependent* made an intentional misrepresentation of material fact (including a misleading omission of material fact). "Material facts" may include, for example, statements or omissions on the application or in the enrollment process, as applicable, made as part of *your* enrollment and claims for coverage or reimbursement that misrepresent an individual's continuing status as a *dependent*.

TIME LIMIT ON CERTAIN DEFENSES. After two years from the date of issue of this *contract*, no misstatement, except fraudulent misstatements, made by *you* in *your* application for this *contract* shall be used to void this *contract* or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

NOTICE. This disclosure is required by Minnesota law. This *contract* is expected to return on average 80% of *your premium* dollar for health care. The lowest percentage permitted by federal and state law for this *contract* is 80%.

RIGHT TO CANCEL. *You* may cancel the *contract* within ten days of its receipt and have the premium paid refunded if, after examination of the *contract*, *you* are not satisfied with it for any reason. *You* are responsible for repaying Aspirus Health Plan, Inc. for any services rendered or claims paid by *us* during the ten days. Aspirus Health Plan, Inc. has the right to cancel this *contract* back to the last paid through date, decline to issue, or not renew this *contract* if required *premiums* are not received when due, or if *we* cease doing business in the individual health plan market.

ACCEPTANCE OF THIS CONTRACT. Except as provided in the preceding paragraph, *our* receipt of the full amount due for *your* first monthly *premium* will signify *your* acceptance of all terms, conditions, and obligations of this *contract*. Acceptance will be effective on the *effective date* of this *contract*.

READ YOUR CONTRACT CAREFULLY.

IN WITNESS WHEREOF, *our* President and Secretary hereby sign this *contract*.

A handwritten signature in black ink, appearing to read "David M. Bittner".

David M. Bittner Interim President

A handwritten signature in black ink, appearing to read "Eric Anderson".

Eric Anderson Secretary

Customer Service	
Questions?	<i>Our</i> Customer Service staff is available to answer questions about <i>your</i> coverage Monday through Friday, 7 AM – 5 PM Central Time When contacting <i>us</i>, please have <i>your member</i> identification card available. If <i>your</i> questions involve a claim, <i>we</i> will need to know the date of service, type of service, the name of the <i>provider</i>, and the charges involved.
Telephone Numbers:	Monday through Friday 7 AM - 5 PM Central Time Toll free..... 1.866.631.4611 Fax..... 763.847.4010 Hearing impaired individuals 711
Website:	<u>www.aspirushealthplan.com</u>
Mailing Address:	Notice of claims, proof of loss, review requests, prior authorization, and written inquiries may be mailed to: Customer Services Department Aspirus Health Plan, Inc. P.O. Box 1890 Southampton, PA 18966-9998

MNsure	
Questions?	If <i>you</i> have questions about <i>your</i> enrollment application and any subsidies, including any appeal rights about <i>your</i> subsidies, contact MNsure at the telephone number, website, or address listed below.
Telephone Numbers:	Telephone..... 1.855.366.7873 Fax..... 651.431.7770
Website:	www.mnsure.org
Mailing Address:	MNsure P.O. Box 64253 St. Paul, MN 55164-0253

Nondiscrimination & Language Access Policy

Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters.
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters.
 - Information written in other languages.

If *you* need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If *you* believe that Aspirus Health Plan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711)
Fax: 763-847-4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help *you*.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. This notice is available at Aspirus Health Plan, Inc.'s website: https://aspirushealthplan.com/webdocs/90006-MN-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Cushitic-Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.866.631.5404 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Traditional Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອັດຕາພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄະນະນີ້ພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY: 711).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.866.631.5404 (መስማት ለተሳናቸው: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Khmer/Cambodian: ឱ្យយកចិត្តទុកដាក់: បើប្រើសំឡេងខ្មែរ ឬខ្មែរ, សេវាជំនួយភាសាខ្មែរមិនគិតថ្លៃ គឺបានសម្រាប់ប្រើប្រាស់។ ទូរស័ព្ទ 1.866.631.5404 (TTY: 711)។

Arabic: (711) اتصل برقم. إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. ملحوظة 1.866.631.5404 (رقم): هاتف الصم والبكم

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.866.631.5404 (ATS: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711) 번으로 전화해 주십시오.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.866.631.5404 (TTY: 711).

Karen: သတိပြုရန်: သင်က ကရင်ဘာသာ ပြောဆိုသူဖြစ်ပါက၊ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို အခမဲ့ လက်ခံနိုင်ပါသည်။ ဖုန်းခေါ်ပါ 1.866.631.5404 (TTY: 711).

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I. Important *Member* Information

Contract Year. *Your* first contract year begins on the *effective date of your* coverage and ends on December 31 of that *calendar year*. Subsequent contract years run on a *calendar year* basis, January 1 through December 31.

Covered Services. This *contract* defines what services are covered by *us* and describes procedures *you* must follow to obtain coverage.

Essential Health Benefits. This *contract* covers all *essential health benefits*. *Essential health benefits* are subject to some limitations or exclusions under this *contract*.

Exclusions. Certain services or medical supplies are not covered. *You* should read this *contract* for detailed explanation of all exclusions.

Providers. Enrolling under this *contract* does not guarantee services by a particular *provider* on the list of *providers*. Except as provided in the “Continuity of Care” provision of this *contract*, when a *provider* is no longer a *participating provider* with *us*, *you* must choose among remaining *participating providers*. Contact Customer Service for the most recent listing of *participating providers* or for information about continuity of care.

Wellness. *We* may offer and provide wellness and fitness incentives to *you* in connection with services received from *us* or designated third party vendors.

II. Important *Enrollee* Information and *Enrollee* Bill of Rights

ENROLLEE INFORMATION

Covered Services: Services provided by Aspirus Health Plan, Inc. will be covered only if services are provided by participating Aspirus Health Plan, Inc. *providers* or authorized by Aspirus Health Plan, Inc. Your *contract* fully defines what services are covered and describes procedures you must follow to obtain coverage.

Providers: Enrolling in Aspirus Health Plan, Inc. does not guarantee services by a particular *provider* on the list of *providers*. When a *provider* is no longer part of Aspirus Health Plan, Inc., you must choose among remaining Aspirus Health Plan, Inc. *providers*.

Referrals: Referrals are not required.

Emergency Services: *Emergency services* from *providers* who are not affiliated with Aspirus Health Plan, Inc. will be covered. Your *contract* explains the procedures and benefits associated with *emergency* care from Aspirus Health Plan, Inc. and non-Aspirus Health Plan, Inc. *providers*.

Exclusions: Certain services or medical supplies are not covered. You should read the *contract* for a detailed explanation of all exclusions.

Continuation: *You* may convert to an individual health maintenance organization *contract* or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in *your contract*.

Cancellation: *Your* coverage may be canceled by *you* or Aspirus Health Plan, Inc. only under certain conditions. *Your contract* describes all reasons for cancellation of coverage.

Newborn Coverage: If your health plan provides for *dependent* coverage, a newborn infant is covered from birth, but only if services are provided by *participating providers* or authorized by Aspirus Health Plan, Inc. *We* will not automatically know of the infant's birth or that *you* would like coverage under *your* plan. *You* should notify *us* of the infant's birth and that *you* would like coverage. If *your contract* requires an additional *premium* for each *dependent*, Aspirus Health Plan, Inc. is entitled to all *premiums* due from the time of the infant's birth until the time *you* notify *us* of the birth. *We* may withhold payment of any health benefits for the newborn infant until any *premiums* *you* owe are paid.

Prescription Drugs and Medical Equipment: Enrolling in Aspirus Health Plan, Inc. does not guarantee that any particular *prescription drug* will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year.

Member Responsibilities: *You* must supply information (to the extent possible) that *we* require for health plan processes such as enrollment, claims payment and benefit management, and providing access to care.

You must advise *us* of any discounts or financial arrangements between *you* and a *provider* or manufacturer for *health care services* that alter the charges *you* pay.

ENROLLEE BILL OF RIGHTS

1. *Enrollees* have the right to available and accessible services including emergency services, as defined in *your contract*, 24 hours a day and seven days a week.
2. *Enrollees* have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.
3. *Enrollees* have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care *providers*, in accordance with existing law.
4. *Enrollees* have the right to file a complaint with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care *providers*.
5. *Enrollees* have the right to a grace period of 31 days for the payment of each *premium* for an individual health maintenance *contract* falling due after the first *premium* during which period the *contract* shall continue in force.
6. Medicare *enrollees* have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law.
7. Medicare *enrollees* have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

III. Disclosure of *Provider* Payments

Participating providers submit claims for *eligible charges* to us with their usual charge for the *health care services*. Your benefits are determined based on the service and the claims' *eligible charges* that are paid according to the applicable *fee schedule*. This may be based on various methodologies, depending on the *provider* type and contract (i.e. per service, per event, per day, by diagnostic related group or percent of charge). The *deductible* and *coinsurance* amounts are based on the *fee schedule* amount.

Post-service claims submitted to us for *non-participating provider* benefits are paid on a *fee-for-service* basis. We determine your benefits based on the *non-participating provider reimbursement value*, *recognized amount*, *qualifying payment amount*, or billed charges, whichever is applicable.

We do not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization. Utilization management decision making is based only on appropriateness of care and service and existence of coverage.

We are required to comply with Minn. Stat. § 62Q.75, subd. 2, which requires prompt payment of clean claims within 30 calendar days of receipt of the clean claim.

IV. Member Information for *Non-Participating Provider* Benefits

Covered Services. We cover specified services from *non-participating providers* at varying levels of coverage. *Deductibles*, *coinsurance*, *copayments* and maximum benefit restrictions may apply. This *contract* lists the services available and describes the procedures for receiving coverage through *non-participating providers*.

Prior Authorization. The section entitled "Prior Authorization Requirement" in this *contract* explains prior authorization requirements.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care *provider*, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a *provider* or visit a health care facility that isn't in your *qualified health plan's* network.

"Out-of-network" means *providers* and facilities that haven't signed a contract with your *qualified health plan* to provide services. Out-of-network *providers* may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's *deductible* or annual *out-of-pocket limit*.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an *emergency* or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network *provider*. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an *emergency medical condition* and get *emergency services* from an out-of-network *provider* or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as *copayments*, *coinsurance*, and *deductibles*). You can't be balance billed for these *emergency services*. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network *hospital* or ambulatory surgical center, certain *providers* there may be out-of-network. In these cases, the most those *providers* can bill you is your plan's in-network cost-sharing amount. This applies to *emergency* medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These *providers* can't balance bill you and may not ask you to give up your protections not to be balance billed.

Balance billing is prohibited when you receive services from a *participating provider* that sends a specimen taken from you in the *participating provider's* practice setting to a *non-participating provider* laboratory, pathologist, or other medical testing facility.

If you get other types of services at these in-network facilities, out-of-network *providers* can't balance bill you, unless you give written consent and give up your protections.

Air Ambulance

Emergency air ambulance transportation that is provided to you by *non-participating providers* will be reimbursed at in-network cost-sharing rates. Non-participating air ambulance providers can't balance bill you. They can only bill you for the usual cost-sharing amount set by your plan, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the *copayments*, *coinsurance*, and *deductible* that you would pay if the *provider* or facility was in-network). Your *qualified health plan* will pay any additional costs to out-of-network *providers* and facilities directly.
- Generally, your health plan must:
 - ✓ Cover *emergency services* without requiring you to get approval for services in advance (also known as "prior authorization").
 - ✓ Cover *emergency services* by out-of-network *providers*.
 - ✓ Base what you owe the *provider* or facility (cost-sharing) on what it would pay an in-network *provider* or facility and show that amount in your explanation of benefits.
 - ✓ Count any amount you pay for *emergency services* or out-of-network services toward your in-network *deductible* and *out-of-pocket limit*.

If you think you've been wrongly billed, please contact Customer Service at 1.866.631.4611 (toll free), or visit our web site at www.aspirushealthplan.com. You may reach the Minnesota Department of Health at 651.201.5100 or 1.800.657.3916 (toll free). The federal phone number for information and complaints is: 1.800.985.3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

You are entitled to an external review of any adverse determination related to your rights and protections described in this section. The process is set forth in Section XIX.

V. General Provisions

A. Introduction to *Your* Coverage under this *Contract*

This *contract* describes *your* health care coverage with *us*. *We* may not cover or pay for all of *your* health care expenses. Read this *contract* carefully to determine which expenses are covered. *We* have discretionary authority to determine eligibility for benefits under this *contract* and to interpret and construe terms, conditions, limitations, and exclusions of this *contract*. Many provisions are interrelated; therefore, reading just one or two provisions may not give *you* a complete understanding of the coverage described under this *contract*. Italicized words used in this *contract* have special meanings and are defined at the back of this *contract*.

B. Non-Emergency Services Received in a *Participating Provider* Facility from a *Non-Participating Provider*

If a *participating provider* arranges and/or performs services for *you* at a *participating provider* facility, all related eligible non-facility charges from both *participating providers* and *non-participating providers* are covered at the *participating provider* level of benefits as shown in the “Description of Benefits.”

If a *non-participating provider* arranges or performs services for *you* at a *participating provider* facility with *your* advance written authorization, all related eligible non-facility charges from any *non-participating providers* are covered at the *non-participating provider* level of benefits, if any, as described in the “Description of Benefits.”

If *you* receive *unauthorized provider services* from a *provider* those services will be covered as required under Minnesota § 62Q.556.

C. Transition of Care and Continuity of Care

Eligibility for transition of care benefits at time of enrollment

You are eligible for transition of care benefits if:

You are, at the time of enrollment:

1. a *continuing care patient*, which means *you* are, with respect to a *provider*:
 - a. Undergoing a course of treatment for a *serious and complex condition*, other disabling or chronic condition that is in an acute phase, other life-threatening mental or physical illness, or other acute condition from the *provider*;
 - b. Undergoing a course of institutional or inpatient care from the *provider*;
 - c. Scheduled to undergo non-elective surgery from the *provider*;
 - d. Either in the second or third trimester of pregnancy and undergoing a course of treatment for the pregnancy from the *provider*;
 - e. Experiencing a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
 - f. Terminally ill and receiving treatment for such illness from the *provider*;
2. Receiving care from this *provider*, and the *provider* is the only culturally appropriate *provider* within 30 miles or 30 minutes travel from *your* place of residence; or
3. Unable to speak English, and Aspirus Health Plan, Inc. does not have a *provider* in its *participating provider* network that can provide care to *you* either directly or through an interpreter.

Your provider must request transition of care benefits at the time of enrollment or as soon as reasonably possible after the *effective date* for *your* coverage.

Eligibility for continuity of care benefits

You are eligible for continuity of care benefits if:

1. *You* are either 1(a), 1(b), 1(c), in any trimester of pregnancy, 1(e) or 1(f) as described above in the **Eligibility for transition of care benefits at time of enrollment** section above; and
2. Either *your* continuity of care *provider's* agreement has terminated or the benefits for which *you* need continuing care with respect to such *provider* terminated because of a change in the terms of the *provider's* agreement.

Your provider must request continuity of care benefits within 30 days of the applicable termination date in section 2 above, or as soon as reasonably possible.

How to request transition of care or continuity of care benefits

1. *Your provider* must either:
 - a. Complete the applicable form:
 - i. Continuity of Care: https://aspirushealthplan.com/webdocs/60024-AHP-Continuity-of-Care-Prior-Authorization-Form_SE.pdf; or
 - ii. Transition of Care: <https://www.aspirushealthplan.com/webdocs/AHP-046-Transition-of-Care-Request-Form.pdf>; or
 - b. contact Customer Service at the telephone number listed on the inside cover of this *contract*.
2. *Your provider* must submit a complete form that includes the *provider's* signature and all required documentation.
3. *You* must request that *your provider* submit the form within the required time frame. Requests received after the required time frame will be denied, unless a longer time frame is required by law or *we* determine that extraordinary circumstances prevented timely submission.

Transition of care and continuity of care benefits

1. If the request is approved, *you* will receive:
 - a. In the case of transition of care, *participating provider benefits* provided under this *contract*, with respect to the course of treatment furnished by *your* transition of care *provider* relating to *your* status as a *continuing care patient*.
 - b. In the case of continuity of care, the *participating provider benefits* provided under this *contract*, under the same terms and conditions as would have applied and with respect to such *health care services* as would have been covered under this *contract* had *you* not become eligible for continuity of care benefits, with respect to the course of treatment furnished by *your* continuity of care *provider* relating to *your* status as a *continuing care patient*.
2. In the case of transition of care, if *you* choose to continue receiving care from the transition of care *provider* beyond the approved time frame, this *contract's* *non-participating provider* coverage provisions will apply after the expiration of the approved time frame, including any applicable prior authorization requirements.
3. *You* have the right to receive an explanation of *our* decision on whether to approve your request for transition of care or continuity of care benefits, including the reason for denial if *your* request was not approved.

Duration of continuity of care and transition of care benefits

Transition of care benefits end on the earlier of the first day following the 120-day period beginning on the effective date of coverage under this *contract* or the date upon which *you* have recovered from *your serious and complex condition*, if applicable.

Continuity of care benefits end on the earlier of the first day following the 120-day period beginning on the applicable termination date or the date upon which *you* have recovered from *your serious and complex condition*, if applicable.

However:

1. If *you* were either in the second or third trimester of pregnancy when *you* became eligible for transition or continuity of care benefits, *participating provider benefits* end after the twelve-week post-partum period.
2. If *your* transition or continuity of care *provider's* agreement was terminated and the termination was not for cause, transition or continuity of care benefits continue through the rest of *your* life if a *physician*, advanced practice registered nurse, or physician assistant certifies that *you* have an expected lifetime of 180 days or less.

D. Referrals and Open Access

Your provider may suggest that *you* receive a *health care service* from a specific *provider* or receive a specific *health care service*. Even though *your provider* may recommend or provide written authorization for a referral for certain *health care services*, the *provider* where *you* receive the *health care services* may be a *non-participating provider* or the recommended *health care service* may be covered at a lesser level of benefits or be specifically excluded. When these *health care services* are referred or recommended, a written authorization from *your provider* does not override any specific network requirements, prior authorization requirements, or plan benefits, limitations or exclusions.

This *contract* provides “open access” coverage. “Open access” coverage means that *you* may elect to receive *your health care services* from any *participating provider* in a *provider* network. The *provider* network includes *specialists*. The *provider* directory or designated website will assist *you* in finding *participating providers*. *You* may schedule appointments with such *participating providers*, including *providers* who specialize in obstetrics/gynecology, without any referral. However, it is important that *you* verify that the *provider* still participates with the *provider* network before *you* actually receive any *health care services*. If *you* have questions about the status of *participating providers*, *you* may call the Customer Service number listed on *your* ID card for assistance.

E. Medical Emergency

You should be prepared for the possibility of a medical *emergency* by knowing *your participating provider's* procedures for “on call” and after regular office hours before the need arises. Determine the telephone number to call, which *hospital your participating provider* uses, and other information that will help *you* act quickly and correctly. Keep this information in an accessible location in case a medical *emergency* arises.

If the situation is a medical *emergency* and if traveling to a *participating provider* would delay *emergency* care and thus endanger *your* health, *you* should go to the nearest medical facility. However, call the phone number shown on *your* id card or *your participating provider* within 48 hours or as soon as reasonably possible to discuss *your* medical condition and to coordinate any follow-up care. *You* may authorize someone else to act on *your* behalf.

F. The Entire Contract

This *contract*, combined with any amendments (and *your* completed application), and any other documents referenced in this *contract*, excluding the Summary of Benefits and Coverage, constitute the entire *contract* between *you* and *us*. No change in this *contract* will be valid until approved by one of *our* executive officers and unless such approval is endorsed hereon or attached hereto. No agent has the authority to change this *contract* or to waive any of its provisions. *We* have the right to rely upon the information provided as part of *your* enrollment.

G. Summary of Benefits and Coverage (SBC)

The SBC is an informational summary of *your* benefits and coverage under this *contract*, including coverage examples, that is prepared in a uniform style. If there is a conflict between this *contract* and the SBC, this *contract* governs and *we* will administer *your* coverage in accordance with this *contract*. *You* can obtain the SBC by contacting Customer Service or accessing the designated website.

H. Your Identification Card

We will issue *you* an identification (ID) card containing coverage information. Please verify the information on the ID card and notify Customer Service if there are errors. If any ID card information is incorrect, claims or bills for *your* health care may be delayed or temporarily denied. *You* will be asked to present *your* ID card whenever *you* receive services.

I. Provider Directory

You may find *participating providers* by going to *our* website at <https://p1.aspirushealthplan.com/find-a-doctor> and signing in to *your* account. In the section of the web page entitled **FIND A DOCTOR**, there are links with the names of the *provider* networks *you* have access to under this *contract*. Clicking on a link will take *you* to the directory of *participating providers* in that *provider* network. Coverage may vary according to *your provider* selection.

The list of *participating providers* frequently changes, and Aspirus Health Plan, Inc. does not guarantee that a listed *provider* is a *participating provider*. *You* may want to verify that a *provider* *you* choose is a *participating provider* by calling Aspirus Health Plan, Inc. Customer Service. If *you* call Customer Service, Aspirus Health Plan, Inc. will respond to *you* as soon as practicable but in no case later than 1 business day after *your* call is received, through a written electronic communication or, at *your* request, a hard copy communication. *Provider* directories are available to *you* upon request.

If either:

1. *You* received through a telephone call to Aspirus Health Plan, Inc. Customer Service, or through an Internet-based *provider* directory made available by Aspirus Health Plan, Inc., information confirming that a *provider* was a *participating provider* with respect to furnishing certain *health care services* but the *provider* which furnished the *health care services* after *you* received such information was a *non-participating provider*; or
2. *We* did not make available an Internet-based *provider* directory and *you* requested before *you* received certain *health care services* through a telephone call to Aspirus Health Plan, Inc. Customer Service information on whether the *provider* was a *participating provider* with respect to furnishing such *health care services* and was informed by Customer Service that the *provider* was a *participating provider*;

Then Aspirus Health Plan, Inc.:

1. Shall not impose on *you* a cost-sharing amount (e.g. a *deductible* or *copayment*) for such *health care services* furnished by the *non-participating provider* that is greater than the cost-sharing amount that would apply had such *health care services* been furnished by a *participating provider*; and
2. Shall apply the out-of-pocket maximum that would apply if such *health care services* were furnished by a *participating provider*.

J. Premium Payment

Your premium payments are due monthly and, other than the first month, must be paid within a certain number of days after the *premium* due date. That number of days is known as the grace period, described further below. If *you* are a recipient of advance payments of the *premium* tax credit under the *Affordable Care Act*, this timely payment requirement applies only to that portion of the *premium* for which *you* are liable, and does not apply to that portion of the *premium* that is paid to *us* through advance payments of the *premium* tax credit. *We* have the right to change the *premium* due date and *premium* rates like *yours* and will notify *you* in advance of any changes. *Your premium* is the same as other *subscribers* of like age and number of *dependents* who are covered under contracts like *yours*. *We* will notify *you* of the new *premium* on *your* billing statement if *your premium* changes.

This *contract* will continue in force as long as *premium* payments are made before the due date or within the grace period described below. *We* have the right to terminate this *contract* due to non-payment of *premium*, rescind this *contract* due to fraud or intentional misrepresentation of a material fact, or to cancel this *contract* as otherwise described in the “Ending *Your Coverage*” provision of this *contract*. This *contract* will not be renewed if *we* cease doing individual market business in Minnesota, or as specified herein. Payment of a claim does not preclude *us* from denying future claims or taking any legal action *we* determine is appropriate, including *rescission* and seeking repayment of claims already paid.

Premium Payment from Third Parties: *We* do not accept *premium* payments from third parties including, but not limited to, employers of *members*, *subscribers* or *dependents*, except when (a) acceptance of payment from a third party is specifically required by applicable federal or state law, (b) payment of the entire monthly *premium* is made from or on behalf of an individual coverage health reimbursement account (ICHRA) by the sponsoring employer, administrator or third party administrator of such ICHRA, (c) payment of the entire monthly *premium* is made from or on behalf of qualified small employer health reimbursement arrangement (QSEHRA) by the sponsoring employer, administrator, or third party administrator of such QSEHRA, or (d) payment is made by an affiliate of *us*. *We* may deny acceptance of, or stop accepting, *premium* payments from third parties only as permitted by applicable federal or state law.

K. Grace Periods

After *your* first payment of *premium*, *we* allow a 31-calendar day grace period for *premium* payment for months in which *you* are not a recipient of advance payments of the *premium* tax credit under the *Affordable Care Act*. The grace period starts on the day after the due date for payment. *You* are covered during this grace period provided payment of *premium* is made by the end of the grace period. If *we* do not receive payment by the end of the grace period, this *contract* is cancelled retroactively to the last date for which coverage has been paid in full.

You have a different grace period applicable only in months in which *you* are a recipient of advance payments of the *premium* tax credit under the *Affordable Care Act*. If *you* previously paid at least one full month’s *premium* during the contract year while receiving advance payments of the *premium* tax credit, *we* must provide *you* a grace period of three consecutive months. During this grace period, *we* must provide benefits for *covered services* *you* receive during the first month of the grace period. If *you* do not fully pay all outstanding *premiums* for the three consecutive months of the grace period by the last day of the grace period, *we* are required to terminate *your* coverage effective as of the end of the first month of the grace period, and *we* will not provide benefits for any *covered services* *you* received during the second and third months of the grace period.

If *your* coverage is terminated for nonpayment, *you* may not be able to obtain new coverage until the next annual open enrollment period, unless *you* experience a qualifying event that provides *you* or *your dependents* a right to a special enrollment or limited open enrollment period under this *contract*. The section entitled “Eligibility, Enrollment and *Effective Date*” in this *contract* explains annual open enrollment, special enrollment, and limited open enrollment periods.

L. Reinstatement at Renewal

If *your* renewal *premium* is not paid by the end of the grace period granted to *you* for payment of such *premium*, *we* will not accept subsequent submission of such *premium* unless it is accompanied by *your* written application request for reinstatement and such application request is approved by *us* as described below. This written application request for reinstatement must be on a form provided by *us* and accompanied by full and complete payment of all *premium* due. *We* will review *your* application request for reinstatement upon receipt.

We may agree in writing to reinstate *your* coverage after the grace period has expired once without a break in coverage.

We will notify *you* in writing if *we* agree to reinstate *your* coverage. After this one time reinstatement, *you* must reapply for coverage during the next annual open enrollment period, unless *you* experience a qualifying event that provides *you* or *your dependents* a right to a limited open enrollment period.

If *we* do not agree to reinstate *your* coverage, *we* are not responsible for claims that are for *covered services* received after *your* coverage under Aspirus Health Plan, Inc. ends.

We have 45 days following receipt of *your* written application request for reinstatement that is submitted in accordance with the procedures of this section to approve or deny such application request. If *we* do not approve or deny *your* application request for

reinstatement within 45 days after receipt of such application request, *your* coverage will be reinstated upon the 45th day following the date such written application request for reinstatement was received by *us*.

This provision for reinstatement at renewal is limited to renewal *premiums*.

M. Changes in Coverage

We may discontinue offering all health insurance in the individual market. If that happens, *we* will provide *you* with written notice that coverage is being discontinued as required by law.

The coverage provided under this *contract* and the *premiums* due for that coverage may change each year. Such changes may include changes in order to meet federal regulatory requirements, or state regulatory requirements to the extent that such requirements are not preempted by federal regulatory requirements, or to ensure that this *contract* maintains the actuarial value for the designated metal levels as defined in the *Affordable Care Act*. Any change in coverage required by statute or regulation becomes effective according to statute or regulation.

We may also modify or non-renew this *contract* on a uniform basis among all individuals with the same coverage as long as such change is in compliance with applicable federal law, or state law to the extent that such law is not preempted by federal law. Aspirus Health Plan, Inc. may also non-renew this *contract* if the *subscriber* has permanently moved outside the Minnesota service area for this *contract*. This *contract* is guaranteed renewable at a *premium* rate that does not take into account *your* claims experience or *your* health status.

If coverage is modified, *we* will provide *you* written notice of the change as required by law.

N. Conflict with Existing Law

If any provision of this *contract* conflicts with any applicable statute or regulation, only that specific provision is hereby amended to conform to the minimum requirements of such statute or regulation.

O. Privacy

We are subject to the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Rule. In accordance with the HIPAA Privacy Rule, *we* maintain, use, or disclose *your* Protected Health Information for purposes such as claims processing, utilization review, quality assessment, case management, and otherwise as necessary to administer *your* health care coverage. *You* will receive a copy of *our* Notice of Privacy Practices (which summarizes *our* HIPAA Privacy Rule obligations, *your* HIPAA Privacy Rule rights, and how *we* may use or disclose health information protected by the HIPAA Privacy Rule) with *your* enrollment packet. *You* may also call Customer Service to receive one.

P. Fraud or Intentional Misrepresentation and Rescission

If routine processing delays or clerical errors occur, those delays will not deprive *you* of coverage for which *you* are otherwise eligible, nor will they give *you* coverage under this *contract* for which *you* are not eligible under this *contract*. *You* will not be eligible for coverage beyond the scheduled termination of this *contract* because of a failure to record or communicate the termination except where required by law. *Your* coverage may not be rescinded unless *you* (or anyone seeking coverage on *your* behalf, including a personal representative) falsify, or intentionally misrepresent or omit, information on *your* enrollment application form, submit fraudulent, altered or duplicate billings for *your* or others’ personal gain, allow another person not covered under this *contract* to use *your* coverage, or perform an act or practice that constitutes fraud or intentional misrepresentation (including an omission) of material fact under the terms of this *contract*. *We* will provide *you* with a minimum of 30 calendar days advance written notice of the pending *rescission*. Notwithstanding this, *your* coverage may be terminated, including being retroactively terminated, due to *your* failure to timely pay *your* required *premiums*.

Q. Authorizations and Right to Audit

For the purpose of managing *your* overall health status, health conditions and diseases; for care coordination and quality improvement purposes; for disease management purposes; for claim processing purposes; and for payment purposes, by enrolling in coverage *you* authorize: (1) *us* to disclose *your* health information with health care *providers* and subcontractors of health care *providers* or of *us* that provide services; and (2) such health care *providers* and subcontractors to disclose *your* health information to each other and to *us*.

Determination of *your* coverage will be made at the time a claim is reviewed. In addition, *we* or *our* designee may require *you* to furnish proof of *your* eligibility status, including eligibility for limited open enrollment, and may, at reasonable times and upon reasonable notice, audit or have audited *your* records regarding eligibility, enrollment, termination, *premium* payments and the coverage provided under this *contract*. If *we* determine that, after reasonable requests, *you* have failed to provide adequate records or authorizations for the release of information, or sufficient proof, *we* may, in *our* sole discretion, deny claims, cancel or not renew *your* coverage or rescind or terminate *your* coverage to the extent permitted by law. In no event will *we* cancel or rescind *your* coverage, except as stated in the “Fraud or Intentional Misrepresentation and Rescission” or the “Ending Your Coverage” sections of this *contract*.

R. Assignment

We will have the right to assign any and all of *our* rights and responsibilities under this *contract* to any of *our* affiliates or to any other appropriate organization or entity.

S. Medical Equipment, Supplies and *Prescription Drugs*

Your coverage under this *contract* does not guarantee that coverage of medical equipment, supplies or *prescription drugs* will continue to be covered, even if the equipment, supply or drug was covered in a previous *calendar year*.

T. Medical Technology and Treatment Review

Depending on the focus of the technology or treatment, one of two committees (Medical Policy Quality Management Subcommittee or the Pharmacy and Therapeutics Quality Management Subcommittee) determines whether new and existing medical treatments and technology should be covered benefits. These committees are made up of *our* designee's staff and independent community *physicians* who represent a variety of medical specialties. Their goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. These committees carefully examine the scientific evidence and outcomes for each treatment/technology being considered. The Quality Management Committee that is made up of independent community *physicians*, a consumer representative, and *our* and *our* designee's staff oversees the decisions of the subcommittees.

U. Recommendations by Health Care *Providers*

In some cases, *your provider* may recommend or provide written authorization for services that are specifically excluded by this *contract*. When these services are referred or recommended, a written authorization from *your provider* does not override any specific *contract* exclusions.

V. Legal Actions

No legal action may be brought until at least 60 calendar days after written proof of loss is provided or after the expiration of three years after the date that written proof of loss was provided.

W. Routine Patient Costs Associated with *Clinical Trials*

We cover routine patient costs associated with a *clinical trial* and may not: 1) deny *your* participation in a *clinical trial*; 2) deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished to *you* in connection with participation in the *clinical trial*; or 3) discriminate against *you* on the basis of *your* participation in a *clinical trial*.

If one or more *participating providers* are participating in a *clinical trial*, we will cover routine patient costs only if *you* participate in the *clinical trial* through a *participating provider* if the *provider* will accept *you* as a participant in the *clinical trial*. This requirement is waived if the approved *clinical trial* is conducted outside the state in which *you* reside. We will not cover routine patient costs if *you* are participating in a *clinical trial* with a *non-participating provider* and *you* do not have coverage for *non-participating provider* benefits.

X. Physical Examinations and Autopsy

In the event we require information from a physical examination or autopsy to properly resolve a claim dispute, we may request this information from *you* or *your* legal representative. Such examinations or autopsy shall be performed at *our* expense. Failure to submit the required information may result in denial of *your* claim.

Y. Time Limit on Certain Defenses

After two years from the date of issue of this *contract*, no misstatement, except fraudulent misstatements, made by *you* in *your* application for enrollment in this coverage shall be used to void this *contract* or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

Z. Limited Access to *Participating Providers*

In the event that we determine that *you* are receiving *health care services* or *prescription drugs* in a quantity or manner that might be harmful to *your* health, we will notify *you* that *your* access to *participating providers* is limited. *You* will have 30 calendar days in which to select one participating *physician*, *hospital* and *pharmacy* to coordinate *your* health care. If *you* do not select those *participating providers* within 30 calendar days, we will select them for *you*.

Under these conditions, failure to receive *health care services* through *your* selected *participating providers* will result in denial of coverage. If *your* condition requires care or treatment from other *providers*, *you* must obtain a written referral from *your* selected participating *physician*.

AA. Good Faith Estimate

At *your* request, if *you* are intending to receive specific *health care services*, we will provide *you* with a good faith estimate of the allowable amount that *we* have contracted with a specified *participating provider* under *our fee schedule* for such specified *health care service*, the portion due from *you* (including *deductible*, *coinsurance*, and *copayments*) and *your* out-of-pocket costs. An estimate provided to *you* under this paragraph is not a legally binding estimate of the *fee schedule* amount or *your* out-of-pocket costs.

We will provide *you* such good faith estimate within ten business days from the day a complete request is received by *us* which includes all the patient and *health care service* information that *we* require to provide a good faith estimate. For purposes of this section, a good faith estimate is not a guarantee of final costs for services received from a *participating provider*, or a final determination of eligibility for coverage of benefits or *provider* network participation under this *contract*.

At *your* request, if *you* are intending to receive specific *health care services*, we will provide *you* with a good faith estimate of the allowable amount that *we* have contracted with a specified *participating provider* under *our fee schedule* for such specified *health care service*, the portion due from *you* (including *deductible*, *coinsurance*, and *copayments*) and *your* out-of-pocket costs. An estimate provided to *you* under this paragraph is not a legally binding estimate of the *fee schedule* amount or *your* out-of-pocket costs.

We will provide *you* such good faith estimate within ten business days from the day a complete request is received by *us* which includes all the patient and *health care service* information that *we* require to provide a good faith estimate. For purposes of this section, a good faith estimate is not a guarantee of final costs for services received from a *participating provider*, or a final determination of eligibility for coverage of benefits or *provider* network participation under this *contract*.

BB. Pharmacist

All benefits provided by this *contract* related to expenses *incurred* for *health care services* provided by a licensed *physician* includes *health care services* by a licensed pharmacist to the extent that the *health care services* are within the licensed pharmacist's scope of practice.

VI. Eligibility, Enrollment, and *Effective Date*

Eligible Individuals. An individual is eligible for coverage as a *subscriber* under this *contract* if, at the time of application, the *subscriber* is a resident in the *geographical service area* for which this *contract* is issued and has been determined by MNSure to be a *qualified individual*.

Note: Coverage will be rescinded in the event of fraud or intentional misrepresentation of material fact (including a misleading omission of material fact) and will be terminated in the event of failure to pay, when due, any required *premium*.

Eligible Dependents. A *subscriber* is permitted to enroll only eligible *dependents*. Eligible *dependents* of the *subscriber* include those individuals whom we have determined to be *qualified individuals* and who meet the requirements of any of the following:

1. Lawful spouse whose marriage to the *subscriber* is valid under applicable law.
2. Children, through end of the calendar year in which the child reaches age 26, including:
 - a. Natural children of a covered *subscriber* from birth.
 - b. Legally adopted children or children placed with the *subscriber* for legal adoption (date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support).
 - c. Children for whom the *subscriber* or the *subscriber's* covered lawful spouse has been appointed legal guardian by a court of law, up to the age stated in the court appointment if less than age 26.
 - d. *Stepchildren* of the *subscriber*.
 - e. Grandchildren of the *subscriber* or the *subscriber's* covered lawful spouse who have resided in the covered grandparent's home continuously since the date of the initial discharge from the *hospital* due to birth and are dependent on the covered grandparent for their financial support.
 - f. A child covered under a valid Qualified Medical Child Support Order, as defined under the Employee Retirement Income Security Act (ERISA) and Minn. Stat. Ann. § 518A.41 regardless of whether the child was born out of wedlock, or the child is not claimed as a dependent on the *subscriber's* federal income tax return, or the child does not reside with the *subscriber* or in the service area.
3. Dependent children who are disabled. Application for extended coverage and proof of incapacity must be furnished to us within 31 calendar days after the dependent child reaches age 26. After this initial proof, we may request proof again at any time during the two-year period following the child's attainment of the limiting age but not more frequently than annually after such two-year period. A dependent child may be eligible for coverage if coverage has not otherwise terminated by us and if the dependent child meets all of the following criteria:
 - a. Is incapable of self-sustaining employment, because of a *physical disability*, developmental disability, mental illness, or mental health disorder; and
 - b. Is dependent on the *subscriber* for a majority of support and maintenance.

The disabled dependent child shall be eligible for coverage as long as the dependent child is and continues to be disabled and dependent on the *subscriber*, unless coverage otherwise terminates under this *contract*.

Note: Coverage will be rescinded in the event of fraud or intentional misrepresentation of material fact (including a misleading omission of material fact) and will be terminated in the event of failure to pay, when due, any required *premium*.

Initial Enrollment and Subsequent Enrollment. The *subscriber* must make written application to enroll, including any eligible *dependents* that the *subscriber* wishes to enroll, during the designated open enrollment period. The *subscriber* may add eligible *dependents* to this *contract* at subsequent annual open enrollment periods. They may also be enrolled in connection with a limited open enrollment period as described in the "Limited Open Enrollment," section below. For further information regarding open enrollment, please contact Customer Service. If you have *subscriber* only coverage and elect coverage for your eligible *dependents* which becomes effective, then you and your *dependents* become subject to the terms and conditions of family coverage.

Newborn Child Enrollment Under Minnesota Law. Newborn infants, including the *subscriber's* newborn grandchildren, who were born while the *subscriber* is covered under this *contract* and enrolled for coverage of two or more *qualified individuals*, and who are otherwise eligible for coverage, will be covered immediately from the moment of birth for illness, injury, congenital malformation, or premature birth, regardless of when notice is received by us. If you submit an application more than 60 calendar days after the date of birth, the newborn will still be covered back to the date of birth; however, there may be claim processing delays until the application is received and any required *premiums* are paid in full. We must receive required payments, if any, from the date of birth before benefits will be paid. The *subscriber* must be covered under this *contract* and enrolled for coverage of two or more *qualified individuals* in order for the newborn infant to also obtain coverage under this *contract*.

Newly Adopted Child Enrollment Under Minnesota Law. Children newly adopted or placed for adoption, who were adopted or placed for adoption while the *subscriber* is covered under this *contract*, and who are otherwise eligible for coverage, will be covered immediately from the moment of adoption or placement for adoption for illness, *injury*, congenital malformation, or premature birth, regardless of when notice is received by *us*. If *you* submit an application more than 60 calendar days after the date of adoption, or placement for adoption, the adopted child will still be covered back to the date of adoption, or placement for adoption; however, there may be claim processing delays until the application is received and any required *premiums* are paid in full. *We* must receive required payments, if any, from the date of adoption or placement for adoption before benefits will be paid. The *subscriber* must be covered under this *contract* in order for the adopted child to also obtain coverage under this *contract*.

Effective Date for Initial Enrollment. The date on which coverage is effective for the *subscriber* and all enrolled *dependents* who are listed on the application depends on the date *you* are approved for coverage by *us* and the date of *our* receipt of the full amount due for *your* first monthly *premium* payment. If the conditions are met on or before December 15 in any calendar year, *your* coverage will be effective January 1 of the following calendar year.

Special Enrollment. If *your* circumstances change, *you*, *your* spouse, and *your dependents* may have a special enrollment right to enroll in this *contract*. The events that may permit such special enrollment in this *contract* are generally described in the chart below; **however, they are subject to change as permitted or required by law, regulatory guidance or applicable market practices.** If one of the listed events applies to *you*, *you* must elect coverage in a timely manner as required by law and must submit *your* completed application and required documentation to obtain coverage under this *contract*.

The timeframe for electing coverage varies with the type of event.

- For events 3, 4, 5, 9.1, 9.2, 9.3, 10, and 16 in the chart below, coverage must be elected no later than 60 calendar days after the date the event occurs. For events involving a child support order or other court orders, the date the event occurs is the date the order is issued.
- For events 1, 2, and 11 in the chart below, coverage must be elected during the period that begins 60 days before and ends 60 days after the date the event occurs. However, if the loss of coverage is a loss of Medicaid or CHIP coverage, coverage may be elected no later than 90 days after the date of the loss of coverage.
- For event 15, coverage may be elected 60 days before the date the event occurs, unless the individual coverage HRA or QSEHRA was not required to provide the notice setting forth its terms at least 90 days before the beginning of the plan year, in which coverage may be elected 60 days before or after the date the event occurs. The triggering event for event 15 is the first day on which coverage for the *qualified individual* or *dependent* under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect.¹
- For events 6, 7, 8, 17, 18 and 20, in the chart below, the coverage election periods vary with the circumstances, but generally cannot exceed 60 days.
- For event 12, 16, 21, 22 and 23 in the chart below, coverage must be elected no later than 60 calendar days from the date of such event.
- For event 19 in the chart below, coverage may be changed once each month.
- Special rules apply to events 13 and 14. MNsure can be contacted **1-800-318-2596 (TTY: 711)** if you have questions about these special rules.
- **Inadequate notice:** Notwithstanding anything to the contrary in this *contract*, if a *qualified individual*, *subscriber*, or *dependent* did not receive timely notice of an event that triggers eligibility for a limited open enrollment period under this *contract*, and otherwise was reasonably unaware that a triggering event described in the chart below occurred, the *qualified individual*, *subscriber*, or when applicable, their *dependent* may select a new plan offered either on or off MNsure within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event.

In addition to electing timely, for events 1, 2, 3 (for marriage), 4 (for marriage), 5, 7, 8 and 11 a *qualified individual* must demonstrate either enrollment in *minimum essential coverage* for at least 1 day during the 60 day period prior to the date of the event or that the *qualified individual* lived in a foreign country or U.S. territory for 1 or more days during the 60 day period prior to the date of the event or lived in a service area where no *qualified health plans* were available through MNsure (i) for 1 or more days during the 60 day period prior to the date of the event or (ii) during their most recent preceding enrollment period (which includes initial, annual or a limited open enrollment period). In addition to electing timely, for event 12, a *qualified individual* must demonstrate that they are currently enrolled in *minimum essential coverage* at the time they seek to enroll in coverage that is separate from the perpetrator's coverage. For further information regarding these special enrollment rules, please contact MNsure at **1-800-318-2596 (TTY: 711)**.

¹ A *qualified individual* or *dependent* will qualify for this special enrollment period regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the *qualified individual* or *dependent* is not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to the triggering event.

Note: If you are a *qualified individual* or a *qualified individual*, as applicable, or a spouse or an eligible dependent child of a *qualified individual* or a *qualified individual*, as applicable, but are not enrolled for coverage under this *contract*, you may also enroll for coverage under this *contract*, as provided by the *Affordable Care Act*, as a result of qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. For further information regarding these limited open enrollment rules, please contact Customer Service.

Effective Date of Coverage Pursuant to Special Enrollment (For MNSure). The *effective date* of coverage for the *subscriber* and/or any eligible *dependents* listed on the enrollment form depends on the date on which MNSure timely receives *your* coverage selection and approves it, and *we* receive the full amount of the first monthly *premium* payment. Unless a different *effective date* is specified below, coverage is effective on the first day of the month following the plan selection, provided that all conditions described in this section are met.

- If the event is the birth, adoption, placement for adoption or child support or other court order in relation to an eligible dependent child as set forth in events 3 or 4 in the chart below, coverage is effective on the date of the birth, adoption, placement for adoption or effective date of the court order; unless the *subscriber* elects that the coverage be effective on the first day of the month following plan selection; provided that all conditions described in this section are met.
- If the event is event 8, 11 or the loss of *minimum essential coverage* or the loss of coverage due to non-renewal (including voluntary non-renewal) or expiration of coverage under a non-calendar year group or individual health plan or an employer-sponsored plan that provides minimum value in accordance with the *Affordable Care Act* and as set forth in events 1 or 2 in the chart below, coverage is effective on the first day of the month following the date of the loss of coverage, provided that the *subscriber* timely elects coverage on or before the date of such loss and provided that all conditions described in this section are met. If the *subscriber* timely elects coverage after the date of such loss of coverage, coverage is effective on the first day of the month following plan selection. For a loss of coverage due to such non-renewal or expiration of coverage, the date of the loss of coverage is the last day of the non-calendar plan year that immediately precedes the renewal date or the last day of the non-calendar plan year in which coverage expired, respectively
- The coverage effective dates for events 6, 7, 13, 14, 15, 17, 18 and 20 have special rules for MNSure to set a coverage effective date.
- If the event is the event in which the *qualified individual* or their *dependent* is enrolled in COBRA or state continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the *qualified individual's* or *dependent's* COBRA continuation coverage or government subsidies completely cease, then coverage is effective on the first day of the month following the date of the loss of coverage, provided that the *subscriber* timely elects coverage on or before the date of such loss and provided that all conditions described in this section are met. If *subscriber* timely elects coverage after the date of such loss of coverage, coverage is effective on the first day of the month following plan selection. The date of such loss is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.
- At the option of the *qualified individual*, *subscriber*, or *dependent* who selects a plan during the 60-day period described above in the bullet entitled **Inadequate Notice**, the insurer or MNSure that issues the plan must provide the earliest effective date that would have been available under these rules for determining the **Effective Date of Coverage Pursuant to Special Enrollment (For MNSure)**, based on the applicable triggering event.

For further information regarding these special enrollment coverage effective dates, please contact MNSure at **1-855-366-7873 (TTY: 711)**.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
1. A <i>qualified individual</i> experiences: ▪ An involuntary loss of other <i>minimum essential coverage</i>², or ▪ A loss of coverage due to non-renewal (including voluntary non-renewal) or expiration of coverage under a non-calendar year group or individual <i>health plan</i>, qualified small employer health reimbursement arrangement or a non-calendar year employer-sponsored plan that provides minimum value in accordance with the <i>Affordable Care Act</i>. The date of the loss of this type of coverage is the last day of the non-calendar year plan or policy year. ▪ A loss of pregnancy-related coverage under Medicaid or state CHIP or a loss of access to health care services through coverage provided to the pregnant woman's unborn child through Medicaid or state CHIP.	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the <i>qualified individual's</i> spouse and/or eligible dependent children	▪ Enroll in this <i>contract</i>. ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add themselves to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
2. A <i>qualified individual's</i> spouse and/or eligible dependent children who also are <i>qualified individuals</i> experience: ▪ An involuntary loss of <i>minimum essential coverage</i>², or ▪ A loss of coverage due to non-renewal (including voluntary non-renewal) or expiration of coverage under a non-calendar year group or individual <i>health plan</i>, qualified small employer health reimbursement arrangement or a non-calendar year employer-sponsored plan that provides minimum value in accordance with the <i>Affordable Care Act</i>. The date of the loss of this type of coverage is the last day of the non-calendar year plan or policy year. ▪ A loss of pregnancy-related coverage under Medicaid or state CHIP or a loss of access to health care services through coverage provided to the pregnant woman's unborn child through Medicaid or state CHIP.	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i>. ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add themselves to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
3. A <i>subscriber</i> newly gains a spouse or becomes a spouse or newly gains an eligible dependent child through marriage, birth, adoption, placement for adoption, child support order or other court order. Note: For marriage, at least one spouse must be able to demonstrate that they had <i>minimum essential coverage</i> as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days prior to the marriage effective date.	▪ The <i>subscriber</i> ▪ Other <i>qualified individuals</i> who are the <i>subscriber's</i> spouse and/or newly acquired eligible dependent children of the <i>subscriber</i> or of the new spouse.	▪ Enroll in this <i>contract</i>. ▪ If <i>qualified individual</i> gained a <i>dependent</i> and is enrolled in this <i>contract</i>, the <i>qualified individual</i> may add the <i>dependent</i> to this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ Change <i>your</i> enrollment to another <i>qualified health plan</i> with the same level of coverage or one metal level higher or lower, if no such coverage is available). ▪ At the option of the <i>qualified individual</i> or <i>dependent</i>, enroll the <i>dependent</i> in any separate <i>qualified health plan</i>.
4. A <i>qualified individual</i> and/or a <i>qualified individual's dependent</i> children who also are <i>qualified individuals</i> newly gains a spouse or becomes a spouse or newly gains an eligible dependent child through marriage, birth, adoption, placement for adoption, child support order or other court order. Note: For marriage, at least one spouse must be able to demonstrate that they had <i>minimum essential coverage</i> as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days prior to the marriage effective date.	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or newly acquired eligible dependent children of the <i>qualified individual</i> or of the new spouse.	▪ Enroll in this <i>contract</i>. ▪ If <i>qualified individual</i> gained a <i>dependent</i> and is enrolled in this <i>contract</i>, the <i>qualified individual</i> may add the <i>dependent</i> to this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ Change <i>your</i> enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ At the option of the <i>qualified individual</i> or <i>dependent</i>, enroll the <i>dependent</i> in any separate <i>qualified health plan</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
5. The <i>qualified individual</i> or <i>dependent</i> who is enrolled in a <i>qualified health plan</i> and loses coverage as a result of: ▪ a loss of dependent status because they are no longer considered a <i>dependent</i>, or ▪ through divorce or legal separation as defined by the state law in the state in which the divorce or legal separation occurs, or ▪ the death of the <i>qualified individual</i> or <i>dependent</i> who is enrolled in a <i>qualified health plan</i>	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i>. ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add themselves to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.
6. MNSure determined that a <i>qualified individual</i> or <i>dependent</i> whose enrollment or non-enrollment in a <i>qualified health plan</i> is unintentional, inadvertent or erroneous as a result of an error, misrepresentation, misconduct or inaction by MNSure, the U.S. Department of Health and Human Services, its instrumentalities, or a non-exchange entity that provided enrollment assistance or conducted enrollment activities.	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i>. ▪ Change your enrollment to another <i>qualified health plan</i>. ▪ Make such other enrollment changes that MNSure allows to correct or eliminate the effects of such error, misrepresentation, misconduct or inaction.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
7. A <i>qualified individual</i> or <i>dependent</i> who is enrolled in a <i>qualified health plan</i> adequately demonstrates to the applicable state authority within the meaning of federal law and in accordance with guidelines and standards established by such authority, that such <i>qualified health plan</i> substantially violated a material provision of its contract in relation to such <i>qualified individual</i> or <i>dependent</i>	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i> ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event, and the <i>qualified individual</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add themselves to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
8. A <i>qualified individual</i>, <i>enrollee</i>, or <i>dependent</i>, permanently moves into <i>our geographical service area</i> or into a new service area in Minnesota, which causes such individual to gain access to a new <i>qualified health plan</i> Note: Must demonstrate that <i>qualified individual</i> or <i>enrollee</i>, or <i>dependent</i>, had <i>minimum essential coverage</i> as described in 26 CFR 1.500A-1(b) for one or more days during the 60 days prior to the effective date of the permanent move.	▪ The <i>qualified individual</i> or <i>enrollee</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i> or <i>enrollee</i>	▪ Enroll in this <i>contract</i> provided that coverage under this <i>contract</i>, including the network of <i>providers</i>, is a <i>qualified health plan</i> that was not previously available to the <i>qualified individual</i>. ▪ The <i>qualified individual</i> or <i>enrollee</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> or <i>enrollee</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> or <i>enrollee</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add themselves to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.
9.1 MNSure determines that the <i>enrollee</i> or the <i>enrollee's dependents</i> who are enrolled in the <i>enrollee's qualified health plan</i> become newly eligible for cost-sharing reductions as defined by the <i>Affordable Care Act</i>: and ▪ The <i>enrollee</i> or <i>dependents</i> are not enrolled in a silver-level <i>qualified health plan</i>.	▪ The <i>enrollee</i> ▪ The <i>enrollee's dependents</i>	▪ The <i>enrollee</i> and <i>dependents</i> may change to a silver-level <i>qualified health plan</i> if they elect to change their <i>qualified health plan</i> enrollment.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE		
These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
9.2 MNSure determines that the <i>enrollee</i> or the <i>enrollee's dependents</i> who are enrolled in the <i>enrollee's qualified health plan</i> become newly ineligible for cost-sharing reductions as defined by the <i>Affordable Care Act</i>; and ▪ The <i>enrollee</i> or <i>dependents</i> are enrolled in a silver-level <i>qualified health plan</i>.	▪ The <i>enrollee</i> ▪ The <i>enrollee's dependents</i>	▪ Change to a <i>qualified health plan</i> one metal level higher or lower if the <i>enrollee</i> and <i>dependents</i> elect to change their <i>qualified health plan</i> enrollment.
10. MNSure determines that the <i>enrollee</i> or the <i>enrollee's dependents</i> who are enrolled in the <i>enrollee's qualified health plan</i> become newly ineligible for advance payments of the premium tax credit as defined by the <i>Affordable Care Act</i>.	▪ The <i>enrollee</i> ▪ The <i>enrollee's dependents</i>	▪ Change to a <i>qualified health plan</i> of any metal level if the <i>enrollee</i> and <i>dependents</i> elect to change their <i>qualified health plan</i> enrollment.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
11. MNsure determines that <i>a qualified individual</i> or <i>dependent</i> enrolled in an eligible employer-sponsored plan: Is newly eligible for the advance payment of premium tax credits as defined by the <i>Affordable Care Act</i> based in part on a finding that such individual is ineligible for qualifying coverage in an eligible employer sponsored plan (includes ineligibility as a result of the employer discontinuing or changing available coverage)	- The <i>qualified individual</i> - Other <i>qualified individuals</i> who are the spouse and/or <i>dependent</i> children of the <i>qualified individual</i>	- Enroll in this <i>contract</i> - If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). - The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. - The <i>qualified individual</i> may add themselves to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
12. A <i>qualified individual</i> who: ▪ Is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B-2 or a <i>dependent</i> or an unmarried victim within a household who is enrolled in <i>minimum essential coverage</i>² and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or ▪ Is a <i>dependent</i> of a victim of domestic abuse or spousal abandonment on the same application as the victim	▪ The <i>qualified individual</i> who is the victim of such abuse or abandonment ▪ Other <i>qualified individuals</i> who are eligible <i>dependents</i> of the victim.	▪ Enroll in this <i>contract</i>. ▪ Any eligible <i>dependents</i> must enroll in this <i>contract</i> at the same time and on the same application as the victim. ▪ End <i>your</i> coverage under this <i>contract</i> in order to enroll in other coverage that is separate from the perpetrator of such abuse or abandonment..

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
13. A <i>qualified individual</i> or <i>dependent</i> who applies for coverage through MNSure during open enrollment <u>or</u> due to a qualifying event, is determined potentially eligible for Medicaid or CHIP, but is determined ineligible after open enrollment ends or more than 60 days after the qualifying event	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i>. ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add themselves to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
14. A <i>qualified individual</i> or <i>dependent</i> who applies for state Medicaid or CHIP during open enrollment, but is determined ineligible after open enrollment ended	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i>. ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for the special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add himself or herself to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.
15. The <i>qualified individual</i> or <i>dependent</i> newly gains access to an individual coverage health reimbursement arrangement (HRA) (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code).	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i>. ▪ Change your enrollment to another <i>qualified health plan</i> that meets the <i>minimum essential coverage</i> requirements.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
16. The <i>qualified individual</i> or <i>dependent</i> – - Experiences a decrease in household income; and - Is newly determined eligible by MNSure for advance payments of the premium tax credit.	- The <i>qualified individual</i> - Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	- Enroll in this <i>contract</i>. - If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). - The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. - The <i>qualified individual</i> may add himself or herself to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.
17. A <i>qualified individual</i> or <i>dependent</i> demonstrates to MNSure that the <i>qualified individual</i> or <i>dependent</i> satisfies other exceptional circumstances in accordance with federal guidelines promulgated under the <i>Affordable Care Act</i>	- The <i>qualified individual</i> - Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	Enroll in this <i>contract</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
18. A <i>qualified individual</i> who provides satisfactory documentation to MNSure to verify eligibility for an affordability program or enrollment in a <i>qualified health plan</i> after termination of enrollment by MNSure due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315.	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i> ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ If <i>dependent</i> qualified for this special enrollment event, and the <i>qualified individual</i> is enrolled in this <i>contract</i>, the <i>qualified individual</i> may add their <i>dependent</i> to this <i>contract</i> if allowed. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.
19. A <i>qualified individual</i> who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, or who is or becomes a <i>dependent</i> of such Indian and is enrolled or is enrolling in a <i>qualified health plan</i> through MNSure on the same application as such Indian.	▪ <i>Qualified individuals</i> who are American Indian or Alaskan Natives, as defined by section 4 of the Indian Health Care Improvement Act	▪ Enroll in this <i>contract</i> or change enrollment to another <i>qualified health plan</i>, but not more frequently than once a month.
20. A <i>qualified individual</i> , <i>enrollee</i> or <i>dependent</i> who demonstrates to MNSure that a material error related to the plan benefits, services area, cost-sharing or premium influenced the <i>qualified individual's</i> , <i>enrollee's</i> or <i>dependent's</i> enrollment in a <i>qualified health plan</i> sold through MNSure.	▪ The <i>qualified individual</i> or <i>enrollee</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i> or <i>enrollee</i>	▪ Enroll in this <i>contract</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
21. A <i>qualified individual</i> or <i>dependent</i> who was not previously a citizen or national of the United States or was not lawfully present in the U.S., gains such status	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i>. ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add himself or herself to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE

These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
22. A <i>qualified individual</i> or <i>dependent</i> is newly eligible to enroll in a <i>qualified health plan</i> due to release from incarceration (excludes release from incarceration pending disposition of charges)	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i>. ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for the special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add himself or herself to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.

SPECIAL ENROLLMENT OR LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER MNSURE		
These Special Enrollment or Limited Open Enrollment Right Events	Apply to these <i>Qualified Individuals</i>	And Permit these Enrollment Changes
23. A <i>qualified individual</i> demonstrates MNSure that they were previously ineligible for advanced payment of premium tax credit solely due to a household income below 100% FPL, while simultaneously ineligible for Medicaid and were living in a non-Medicaid expansion state, who becomes newly eligible for advanced payment of premium tax credit after experiencing a change in household income or moves to Minnesota, which results in becoming newly eligible for advanced payment of premium tax credit	▪ The <i>qualified individual</i> ▪ Other <i>qualified individuals</i> who are the spouse and/or eligible dependent children of the <i>qualified individual</i>	▪ Enroll in this <i>contract</i>. ▪ If the <i>qualified individual</i> qualifies for this special enrollment event, the <i>qualified individual</i> and <i>dependent</i> (if applicable) may change the enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available). ▪ The <i>dependent</i> may be added to this <i>contract</i> if the <i>contract</i> allows and if the <i>dependent</i> qualified for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>qualified individual</i> (who does not also qualify for the special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>dependent</i> to enroll, the <i>qualified individual</i> and <i>dependent</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>. ▪ The <i>qualified individual</i> may add themselves to this <i>contract</i> if the <i>contract</i> allows and if the <i>qualified individual</i> qualifies for this special enrollment event and is not enrolled in this <i>contract</i>, and the <i>dependent</i> (who does not also qualify for this special enrollment event) is enrolled in this <i>contract</i>. If the <i>contract</i> does not allow the <i>qualified individual</i> to enroll, the <i>dependent</i> and <i>qualified individual</i> may change their enrollment to another <i>qualified health plan</i> with the same level of coverage (or one metal level higher or lower, if no such coverage is available) or enroll the new <i>qualified individual</i> in a separate <i>qualified health plan</i>.

² For purposes of this *contract*, a loss of *minimum essential coverage* when seeking the coverage through MNSure includes, but is not limited to, the following examples: (i) termination of coverage under a state Medicaid Plan (including pregnancy-related coverage under Medicaid) or a state CHIP plan (including CHIP for unborn children) (due to a loss of eligibility for such coverage provided that the individual who experienced such loss is eligible, but not currently enrolled, for coverage under this *contract*); (ii) expiration of COBRA and any state continuation coverage due to exhaustion of such coverage; (iii) termination of coverage, that is not COBRA or state continuation coverage, due to a loss of eligibility for such coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in hours by the primary insured subscriber under a group plan, cessation of dependent status, and a loss of coverage provided through an HMO or other arrangement due to the individual no longer residing or working in the service area designated by the HMO or other arrangement); (iv) termination of all employer contributions toward the cost of such coverage; or (v) termination of the *qualified individual's* or *dependent's* coverage under an employer-sponsored plan that is not affordable or does not provide minimum value as defined by the *Affordable Care Act*.

For purposes of coverage through MNsure, loss of *minimum essential coverage* does not include, and is not limited to, the following examples: (i) voluntary termination of *minimum essential coverage* or non-*minimum essential coverage*; (ii) loss of non-*minimum essential coverage* unless an exception applies; (iii) loss of *minimum essential coverage* due to a failure to pay *premiums* on a timely basis including COBRA *premiums* while on COBRA continuation coverage; and (iv) loss of coverage due to a rescission of coverage (as permitted under the *Affordable Care Act*) by *us*, another carrier, a regulatory or government agency or an employer due to fraud or an intentional misrepresentation of material fact.

Special Enrollment Period under the *Affordable Care Act*. If you are a *qualified individual* or a *qualified individual*, as applicable, or a spouse or an eligible *dependent* child of a *qualified individual* or a *qualified individual*, as applicable, but are not enrolled for coverage under this *contract*, you may also enroll for coverage under this *contract*, as provided by the *Affordable Care Act*, as a result of qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. For further information regarding these special enrollment rules, please contact Customer Service.

VII. Schedule of Payments

You are required to pay any *copayment, deductible and coinsurance* amounts. Benefits are covered in this *contract* according to what *we* pay for *covered services* that *we* determine are *medically necessary*. *Medically necessary* is defined in the Definitions section of this *contract*. Your *coinsurance* amount is the *eligible charge* for a *covered service* less the percentage covered by *us*. Our payment begins after *you* have satisfied any applicable *copayment, deductible and coinsurance*.

Discounts negotiated by or on behalf of *us* with *providers* may affect your *copayment or coinsurance* amount. We pay higher benefits if *you* choose *participating providers*. In addition to any *copayment, coinsurance and deductible*, *you* also pay all charges that exceed the *non-participating provider reimbursement value*, when applicable.

Note: Your coverage is either “subscriber only” or “family.” Therefore, only one of the following sections “Subscriber only” or “Family” applies to *you*. If *you* have questions about which section applies to *you*, contact Customer Service.

If *you* have *subscriber only* coverage, on the date that the coverage for *your* eligible *dependent(s)* becomes effective, *you* and *your* new *dependent(s)* become subject to the terms and conditions of family coverage.

Subscriber only

Deductible: The *subscriber* must first satisfy the *deductible* by incurring charges equal to that amount for eligible services in a *calendar year* before *we* will pay benefits. We will not pay benefits for the *eligible charges* applied toward the *deductibles*. Expenses *you* pay for *copayments, coinsurance* and any amount in excess of the *non-participating provider reimbursement value* will not apply towards satisfaction of the *deductible*. *You* will not be required to satisfy the *deductible* before *we* will pay benefits for *preventive health care services* received from a *participating provider*.

Out-of-Pocket Limit: This is the amount of *copayments, deductible and coinsurance* the *subscriber* pays per *calendar year* and is shown in the table below. After the *subscriber* has met the *out-of-pocket limit* we cover 100% of charges *incurred* for all other *eligible charges*. It is the *subscriber's* responsibility to pay any amounts greater than the *out-of-pocket limit* if any benefit or visit maximums are exceeded. Expenses *you* pay for amounts in excess of the *non-participating provider reimbursement value* will not apply towards satisfaction of the *out-of-pocket limit*.

Subscriber only	Participating Provider Network	Non-Participating Providers
Deductible	\$500 per <i>calendar year</i> for <i>eligible charges</i> received from <i>participating providers</i> , charges calculated for <i>non-participating providers</i> of <i>emergency services</i> , charges calculated for <i>non-participating providers</i> of <i>air ambulance services</i> , and charges calculated for <i>non-participating providers</i> of <i>non-emergency services</i> at a <i>hospital</i> or <i>ambulatory surgical center</i> which is a <i>participating provider</i> .*	Not applicable.
Out-of-Pocket Limit	\$3,400 per <i>calendar year</i> for <i>eligible charges</i> received from <i>participating providers</i> , charges calculated for <i>non-participating providers</i> of <i>emergency services</i> , charges calculated for <i>non-participating providers</i> of <i>air ambulance services</i> , and charges calculated for <i>non-participating providers</i> of <i>non-emergency services</i> at a <i>hospital</i> or <i>ambulatory surgical center</i> which is a <i>participating provider</i> .*	Not applicable.

Family (Subscriber and Enrolled Dependents)

Family Deductible: If you have family coverage, each covered family member must meet their own individual *deductible* until the total amount of *deductible* expenses paid by all family *members* meets the overall family *deductible*. We will not pay benefits for the *eligible charges* applied toward the family *deductible*. Expenses the family pays for *copayments*, *coinsurance* and any amount in excess of the *non-participating provider reimbursement value* will not apply towards satisfaction of the family *deductible*. Members of the family will not be required to satisfy the family *deductible* before we will pay benefits for *preventive health care services* received from a *participating provider*.

Family Out-of-Pocket Limit: This is the amount of *copayments*, *deductible* and *coinsurance* the family pays per *calendar year* and is shown in the table below. If you have family coverage, each family member must meet their own individual *out-of-pocket limit* for *copayments*, *coinsurance* and *deductible*, until the overall family *out-of-pocket limit* has been met, after which we cover 100% of charges *incurred* for all other *eligible charges*. The family must pay any amounts greater than the family *out-of-pocket limit* if any benefit or visit maximums are exceeded. Expenses the family pays for amounts in excess of the *non-participating provider reimbursement value* will not apply towards satisfaction of the family *out-of-pocket limit*.

Family (Subscriber and Dependents)	Participating Provider Network	Non-Participating Providers
Family Deductible	\$1,000 per family (\$500 per member) per calendar year for <i>eligible charges</i> received from <i>participating providers</i> , charges calculated for <i>non-participating providers</i> of <i>emergency services</i> , charges calculated for <i>non-participating providers</i> of air ambulance services, and charges calculated for <i>non-participating providers</i> of non-emergency services at a hospital or ambulatory surgical center which is a <i>participating provider</i> .*	Not applicable.
Family Out-of-Pocket Limit	\$6,800 per family (\$3,400 per member) per calendar year for <i>eligible charges</i> received from <i>participating providers</i> , charges calculated for <i>non-participating providers</i> of <i>emergency services</i> , charges calculated for <i>non-participating providers</i> of air ambulance services, and charges calculated for <i>non-participating providers</i> of non-emergency services at a hospital or ambulatory surgical center which is a <i>participating provider</i> .*	Not applicable.

Cost-sharing: The amounts of the flat fee *copayments* are calculated on *provider* allowed charges. The *provider's* allowed charge is the full amount that the *provider* bills less any discount negotiated by or on behalf of Aspirus Health Plan, Inc. with the *provider*. The calculation of the *coinsurance* is based on the least of the *provider's* allowed charge, the *fee schedule* negotiated by or on behalf of Aspirus Health Plan, Inc. with the *participating provider*, or the *non-participating provider reimbursement value*, except for: (1) the calculation of the *coinsurance* for *emergency services* provided by a *non-participating provider*, in which case, the calculation of the *coinsurance* will be based on the *recognized amount*; (2) the calculation of the *coinsurance* for air ambulance services provided by a *non-participating provider*, in which case, the calculation of the *coinsurance* will be based on the lesser of the *qualifying payment amount* and billed charges; and (3) the calculation of the *coinsurance* for *non-participating providers* of non-emergency services at a hospital or ambulatory surgical center which is a *participating provider*, in which case, the calculation of the *coinsurance* will be based on the *recognized amount*.* The *deductible* is first subtracted from the allowed charge, *fee schedule*, the *non-participating provider reimbursement value*, the *recognized amount*, or the amount calculated for air ambulance services provided by a *non-participating provider*, whichever is applicable, then the *coinsurance* percentage is applied to the remainder.

* If a *non-participating provider* provides non-emergency health care services at a hospital or ambulatory surgical center which is a *participating provider* and the *non-participating provider* has satisfied the notice and consent requirements described in Section IV. of this contract entitled “What is “balance billing” (sometimes called “surprise billing”)?”, then Aspirus Health Plan, Inc. will pay for charges for such non-emergency health care services according to the terms of the *non-participating*

provider benefits in the table in Section IX.I. *Hospital Services* and any amounts paid by *you* toward the *deductible* and as *coinsurance* for charges for such *non-emergency health care services* will count toward the *deductible* and *out-of-pocket limit* for *non-participating providers*.

VIII. Prior Authorization

Whether or not we grant prior authorization, payment for services will depend on whether, at the time the services are performed, you are a member who is *eligible* for and enrolled under this *contract*, the services are *medically necessary*, are *covered services*, you have provided the appropriate information for those services, and you have met all other terms of the *contract*. Please read the entire *contract* to determine which other provisions might also affect benefits.

If your attending *provider* requests prior authorization on your behalf, the attending *provider* will be treated as your authorized representative by us for purposes of such request and the submission of your claim and associated appeals unless you specifically direct otherwise to us within ten business days from our notification that an attending *provider* was acting as your authorized representative. Your direction will apply to any remaining appeals.

Prior Authorization Requirement. For consideration of coverage, you or your *provider* must request prior authorization for certain *health care services* to determine whether they are *medically necessary*.

- **Participating provider services:** When a *participating provider* renders services, the *provider* will obtain authorization in advance from us or our designee for you by following the procedures explained in this section of this *contract*.
- **Non-participating provider services:** It is your responsibility to obtain an approved Out-of-Network Exception and service-specific prior authorization from us, as outlined in this section, and to follow the procedures in this section of the *contract* when you receive services from *non-participating providers*.

If you have questions about prior authorization, please contact Customer Service. Penalties do not apply.

You and your *provider* should follow the procedures for prior authorization appeals as shown in the “Internal Appeals Process” section. The prior authorization process is required for consideration of coverage for a variety of services including, but not limited to, those listed below, and additional services specified in our “Prior Authorization List”:

1. All non-emergency inpatient admissions including *skilled nursing facility*, rehabilitation, *hospital*, etc.;
2. *Transplant services*;
3. Drugs or procedures that could be construed to be *cosmetic*;
4. Home health care or hospice, except pediatric hospice services provided by a licensed hospice *provider*;
5. Non-emergency transportation
6. Outpatient surgeries;
7. Physical therapy, occupational therapy, speech therapy and other outpatient therapies;
8. Pain therapy, except through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists;
9. *Reconstructive surgery*; and
10. Durable medical equipment (DME) or *prosthesis* with a total purchase price or cumulative rental cost or expected allowance exceeding \$500.

You can access the current list by logging in to your member home page at www.aspirushealthplan.com.

For consideration of coverage, you or your *provider* are also required to request prior authorization for certain *prescription drugs* before you fill your prescription at a pharmacy. These *prescription drugs* include, but are not limited to:

1. *Compounded drugs* that are over \$200;
2. *Specialty drugs*; and
3. Other *prescription drugs* listed on the *formulary* as requiring prior authorization.

Prior Authorization of Treatment of a Chronic Health Condition. An authorization for treatment of a *chronic health condition* does not expire unless the standard of treatment for that *chronic health condition* changes.

Prior Authorization Procedure for Non-Acute Care Pre-Service Requests. When a *participating provider* renders services, the *participating provider* will notify us for you and must follow the procedures set forth below. It is your responsibility to ensure that we have been notified when *non-participating providers* are used. You or the *provider* must contact Customer Service by telephone, facsimile, electronic mail, or voice mail prior to services being performed and without unreasonable delay.

For *non-participating providers*, you need to follow the procedures set forth below:

1. You must contact Customer Service by telephone, facsimile, electronic mail, or voice mail prior to *health care services* being performed, and no less than 15 calendar days prior to the date services are scheduled. An expedited review is available if your attending *health care professional* believes it is warranted.
2. You and the *provider* will be notified of our initial determination within five business days following receipt of your request or by the date on which the services are scheduled to be rendered, whichever is earlier.

3. The initial determination will be communicated to the *provider* by telephone, by fax to a verified number, or by e-mail to a secure electronic mailbox. If an adverse determination is made, a written notification will also be sent if the initial communication was made by telephone.
4. All initial determinations that a service will not be covered will be reviewed by a *physician* who holds a current, unrestricted license to practice medicine and has the same or similar medical specialty as a *provider* that typically treats or manages the condition for which pre-certification was requested. A prior authorization request for a *prescription drug* must be conducted by a licensed pharmacist or a *physician* who is competent to evaluate the specific clinical issues presented in the review. If, after such *physician* or pharmacist review, the initial determination is that the service will not be covered, *your attending health care professional* and *hospital or provider's office* (if applicable) will be promptly notified by telephone within the time periods specified in #2 above.
5. Written notification will then be provided to *you*, *your attending health care professional* and *hospital or provider's office* (as applicable) explaining all reasons relied on by *us* for the determination. The notification will also include the process to appeal the decision.
6. If *you* or the *provider* has not submitted the request for review in accordance with these procedures, *we* will notify *you* within five calendar days.
7. **Note:** If *your* request is denied, *you* may appeal that decision. Refer to the section entitled “Internal Appeals Process” for details on how to appeal.

Should any part of Minnesota be declared subject to a pandemic alert, or in the event of a cyber-attack, *we* may suspend prior authorization and other services in the affected area as may be determined by *us*.

How to Obtain an Expedited Review

Expedited Review. An expedited initial determination will be used if *your attending health care professional* believes it is warranted. Acute care services, which can warrant expedited review, are medical care or treatment with respect to which the application of the time periods for making non-expedited review determinations could seriously jeopardize *your* life or health or *your* ability to regain maximum function, or that in the opinion of *your attending health care professional* would subject *you* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *pre-service claim*.

An expedited initial determination will be provided to *you*, *your attending health care professional*, and *hospital or provider's office* (as applicable) as quickly as *your* medical condition requires, but no later than 48 hours following the initial request, as long as that 48 hours includes at least one business day. If *we* do not have all information *we* need to make a determination, *you* will be notified within 24 hours. *You* will then have at least 48 hours to provide the requested information. *You*, *your attending health care professional* and *hospital or provider's office* (as applicable) will be notified of the determination within 48 hours after the earlier of *our* receipt of the requested information or the end of the time period specified for *you* to provide the requested information. If the initial determination would deny coverage, *you* or *your attending health care professional* will have the right to submit an expedited appeal.

Note: If *your* request is denied, *you* may appeal that decision. Refer to the section entitled “Internal Appeals Process” for details on how to appeal.

Change in Health Plan/Prior Authorization by Previous Utilization Review Organization

If *you* are a new *member* to Aspirus Health Plan, Inc., *we* shall comply with a prior authorization for *health care services* approved by the utilization review organization used by *your* previous health benefit plan for at least the first 60 days that *you* are covered under this *contract*. In order to obtain coverage for this 60-day time period, *you* or *your attending health care professional* must submit documentation of the previous prior authorization to *us*. During this 60-day time period, *we* will conduct *our* own utilization review of these *health care services*.

Change in Coverage Terms or Prior Authorization Clinical Criteria

If, during a *calendar year*, *we* change coverage terms or the clinical criteria used to conduct prior authorizations for a *health care service*, the change in coverage terms or change in clinical criteria shall not apply until the next *calendar year* for *you* if *you* received prior authorization for such *health care service* using the coverage terms or clinical criteria in effect before the effective date of the change.

The above extension of coverage through the end of the *calendar year* does not apply if *we* change coverage terms for a drug or medical device that has been deemed unsafe by the United States Food and Drug Administration (FDA); that has been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug- or device-specific warnings or recommended changes in drug or device usage.

The above extension of coverage through the end of the *calendar year* does not apply if *we* change coverage terms for a *health care service* or the clinical criteria used to conduct prior authorizations for a *health care service* when an independent source of research,

clinical guidelines, or evidence-based standards has recommended changes in usage of the *health care service* for reasons related to patient harm.

The above extension of coverage through the end of the *calendar year* does not apply if *we* remove a brand name drug from *our formulary* or place a brand name drug in a benefit category that increases *your* cost, provided *we* (1) add to *our formulary* a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to *you*, and (2) provide at least a 60-day notice to *you* and *participating providers*.

Case Management

In cases where *your* condition is expected to be or is of a serious nature, *we* may arrange for review and/or case management services from a professional who understands both medical procedures and *our* health care coverage.

Under certain conditions, *we* will consider other care, services, supplies, reimbursement of expenses or payments for care of *your* serious *sickness* or *injury* that would not normally be covered. *We* and *your provider* will determine whether any medical care, services, supplies, reimbursement of expenses or payments will be covered. Such care, services, supplies, reimbursement of expenses or payments will not be considered as setting any precedent or creating any future liability.

Other care, treatments, services, or supplies must meet both of these tests:

1. Be determined in advance by *us* to be *medically necessary* and cost effective in meeting *your* long term or intensive care needs in connection with a catastrophic *sickness* or *injury*; and
2. The charges *incurred* would not otherwise be payable or would be payable at a lesser percentage.

Alternative Care

If *your attending health care professional* advises *you* to consider alternative care for a *sickness* or *injury* that includes *health care services* not covered under the *contract*, *your attending health care professional* should contact *us* so *we* can discuss it with them. *We* have full discretionary authority to consider paying for such non-covered *health care services* and *we* may consider an alternative care plan if *we* find that:

1. The recommended alternative care offers a medical therapeutic value equal to or greater than the current treatment or *confinement*;
2. The current treatment or *confinement* is covered under the *contract*;
3. The current treatment or *confinement* may be changed without jeopardizing *your* health; and
4. The *health care services* provided under the alternative care plan will be as cost effective as the *health care services* provided under the current treatment or *confinement* plan.

We will make each alternative care coverage determination on a case-by-case basis and no decision will set any precedent for future claims. Payment of benefits, if any, will be determined by *us*.

Any alternative care decision must be approved by *you*, the *attending health care professional*, and *us* before such alternative care begins.

IX. Description of Benefits

1. Also refer to the Schedule of Payments to help determine *your* benefit level.
2. See the Prior Authorization section for certain services.
3. Be sure to review the list of Exclusions. A *provider* recommendation or performance of a service, even if it is the only service available for *your* particular condition, does not mean it is a *covered service*. Benefits are not available for *medically necessary* services, unless such services are also *covered services*, and received while *you* are covered under this *contract*.
4. Benefits are limited to the most cost effective and *medically necessary* alternative.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits, we pay:</i>
		**Note: For <i>non-participating providers</i> , in addition to any <i>deductible</i> and <i>coinsurance</i> , you pay all charges that exceed the <i>non-participating provider reimbursement value</i> , when applicable.

A. Ambulance Services		
Non-air ambulance services Note: Prior authorization by <i>us</i> or <i>our</i> designee is required for non-emergency transportation services.	Emergency Services 80% of <i>eligible charges</i> after the <i>deductible</i> . Non-emergency Transportation 80% of <i>eligible charges</i> after the <i>deductible</i> .	Emergency Services Same as the <i>participating provider benefits</i> . Non-emergency Transportation 80% of <i>eligible charges</i> after the <i>participating provider deductible</i> .**
Non-air ambulance medical facility transfer for mother and newborn(s) required under Minnesota Statutes § 62A.0411	Emergency Services 100% of <i>eligible charges</i> . <i>Deductible</i> does not apply. Non-emergency Transportation 100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Emergency Services Same as the <i>participating provider benefits</i> . Non-emergency Transportation 100% of <i>eligible charges</i> after the <i>participating provider deductible</i> .**
Air ambulance services Note: Prior authorization by <i>us</i> or <i>our</i> designee is required for non-emergency transportation services.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Same as the <i>participating provider benefits</i> .*
Air ambulance medical facility transfer for mother and newborn(s) required under Minnesota Statutes § 62A.0411	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Same as the <i>participating provider benefits</i> .*

***Air ambulance services.** Covered air ambulance services provided by a *non-participating provider* are subject to the same *deductible* and *coinsurance* requirements that would apply if the services were provided by a *participating provider* of air ambulance services. The *deductible* and *coinsurance* requirements must be calculated based on the lesser of the *qualifying payment amount* and the billed amount for the services.

Ambulance services for an emergency. We cover ambulance service and *emergency* transportation to the nearest *hospital* or medical center where initial care can be rendered for a medical *emergency*. Air ambulance is covered only when the condition is an acute medical *emergency* and is authorized by a *physician*. Prior authorization by *us* or *our* designee is required for non-emergency transportation.

We cover *emergency* ambulance (air or ground) transfer from a *hospital* not able to render the *medically necessary* care to the nearest *hospital* or medical center able to render the *medically necessary* care only when the condition is a critical medical situation and is ordered by a *physician* and coordinated with a receiving *physician*.

Ambulance services for a non-emergency. Non-emergency ambulance service, including transfers from *hospital* to *hospital* when care for *your* condition is not available at the *hospital* where *you* were first admitted, from a *hospital* to other facilities for subsequent covered care or from home to *physician* offices or other facilities for outpatient treatment procedures or tests, are covered if medical supervision is required en route. Prior authorization by *us* or *our* designee is required in advance of non-emergency ambulance services.

Medical facility transfer for mother and newborn(s) as required under Minnesota Statutes § 62A.0411. Notwithstanding any provision with a benefit to the contrary, if the *attending health care professional* recommends that either the mother or newborn(s) be transferred to a different medical facility, *we* will provide coverage of medical transport for the mother, newborn, and newborn sibling(s) to such new medical facility. The coverage includes but is not limited to expenses related to transferring all individuals from one medical facility to a different medical facility.

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. Non-emergency ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits:</i>
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B. Chiropractic Services		
Services to treat musculoskeletal conditions by manual manipulation therapy. Note: Some services that may be provided during an office visit may be subject the <i>deductible</i>, such as, but not limited to, radiology.	100% of <i>eligible charges</i> for the first four primary care office visits per <i>member per calendar year</i>. Thereafter: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$30 per visit. <i>Deductible</i> does not apply.	Not covered.

NOTE: For coverage of other therapy services, please refer to the section entitled “Physical Therapy, Occupational Therapy and Speech Therapy”

Treatment is limited to conditions related to the spine or joints.

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. *Maintenance care.*
- c. Blood, urine or hair analysis.
- d. Manipulation under anesthesia.

Benefit	Participating Provider Benefits, we pay:	Non-Participating Provider Benefits:
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C. Dental Services		
Accidental Dental Services.	Note: Treatment and repair must be started within six months of the date of <i>injury</i> and completed within twelve months of the date of the <i>injury</i> .	
	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
Medically Necessary Outpatient Dental Services and Hospitalization for Dental Care.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

This provision does not provide coverage for preventive dental procedures. *We* consider dental procedures to be services rendered by a *dentist* or *dental specialist* to treat the supporting soft tissue and bone structure.

We cover the following dental services:

1. **Accidental Dental Services.** *We* cover services to treat and restore damage done to sound, natural teeth as a result of an accidental *injury*. Coverage is for external trauma to the face and mouth only, not for cracked or broken teeth that result from biting or chewing. A sound, natural tooth is a tooth without pathology (including supporting structures) rendering it incapable of continued function for at least one year. Treatment and repair must be started within six months of the date of *injury* and completed within twelve months of the date of the *injury*.
2. **Medically Necessary Dental Services:** *We* cover dental services required for treatment of an underlying medical condition (e.g. removal of teeth to complete radiation treatment for cancer of the jaw, cysts, and lesions) and provided by a *dentist* or *dental specialist*, including general anesthesia, regardless of whether the services are provided in a *hospital* or a dental office.
3. **Medically Necessary Hospitalization for Dental Care:** *We* cover hospitalization for dental care. This is limited to charges incurred by a *member* who: (a.) is a child under age 5; (b) is severely disabled; or (c) has a medical condition that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/*dentist* or *dental specialist* professional fees are not covered for dental services provided, except as described in item 2 above. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Care must be directed by a *physician* or by a *dentist* or *dental specialist*.

Exclusions:

- a. Please see the section entitled "Exclusion List."
- b. Dental services covered under *your* dental plan.
- c. Preventive dental procedures.
- d. *Health care services* or dental services for and related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts.
- e. Orthodontia and all associated expenses, except for the treatment of cleft lip and cleft palate.
- f. *Health care services* or dental services for or related to *oral surgery* and anesthesia for the removal of impacted teeth, removal of a tooth root without the removal of the whole tooth and root canal therapy.
- g. *Health care services* or dental services for cracked or broken teeth that result from biting, chewing, disease or decay.
- h. Dental implants, except due to *injury*.
- i. Prescriptions written by a *dentist* unless in connection with dental procedures covered by *us*.
- j. *Health care services* or dental services related to periodontal disease.
- k. Occlusal adjustment or occlusal equilibration.
- l. Treatment of bruxism.
- m. Surgical extraction of impacted wisdom teeth, except as above for accidental *injury* to sound, natural teeth or when required for treatment of an underlying medical condition.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits:</i>
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D. Durable Medical Equipment (“DME”) Services, <i>Prosthetics</i>, and <i>Orthotics</i>		
DME.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
<i>Orthosis</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
<i>Prosthesis</i>	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
Insulin pump	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
<i>Related medical supplies</i> for diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors.	100% of <i>eligible charges</i> after a <i>copayment</i> of \$50 per month in total for all <i>related medical supplies</i> . The cost-sharing limit for <i>related medical supplies</i> does not increase with the number of <i>chronic diseases</i> for which the <i>enrollee</i> is treated. Coverage under this section shall not be subject to any <i>deductible</i> .	Not covered.
Special dietary treatment for phenylketonuria (PKU) is covered when recommended by a <i>physician</i> , physician assistant or advanced practice registered nurse.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
<i>Medically necessary</i> amino acid based elemental formulas	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
Intermittent urinary catheters and insertion supplies as prescribed by <i>your attending health care professional</i> , up to 180 per month.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
Scalp hair prosthesis for hair loss suffered as the result of <i>illness</i> , including but not limited to alopecia areata or treatment for cancer. Limited to one prosthesis per <i>calendar year</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

We cover equipment and services ordered by a *physician* and provided by DME/prosthetic/orthotic vendors. For verification of eligible equipment and supplies, contact Customer Service at the phone number shown on the inside cover of this *contract*.

Coverage for orthotic and prosthetic devices, supplies and services, including internal restorative devices, if such device would be covered under Medicare. Coverage also includes repair and replacement of such devices.

We cover *orthosis* and *prosthesis* when prescribed by a *physician* or *attending health care professional*. Coverage includes coverage for orthotic and prosthetic devices or device systems, supplies, accessories, and services that are customized to *your* needs.

We cover *orthoses* and *prostheses* determined by *your attending health care professional* to be the most appropriate model that meets *your* medical needs of purposes of performing physical activities, as applicable, including but not limited to running, biking, and swimming, and maximizing *your* limb function. *We* cover *orthoses* and *prostheses* for showering or *bathing*.

We shall render prior authorization determinations in a non-discriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits including *prostheses* or *orthoses*, solely on the basis of an *enrollee's* actual or perceived disability. *We* shall not deny a *prosthesis* or *orthosis* for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

In the event that *medically necessary* covered *orthoses* and *prostheses* are not available from a *participating provider*, you may contact Customer Service at the phone number that appears on the inside cover of this *contract*. We will refer you to a *non-participating provider* and shall work to negotiate rates with such *non-participating provider*. Your cost-sharing shall be the same as it would be had you seen a *participating provider*.

We cover replacement of a *prosthesis* or *orthosis* or any part thereof if your *attending health care professional* determines that a replacement *prosthesis* or *orthosis* or part thereof is necessary because 1) of a change in your physiological condition. 2) of an irreparable change in the condition of the device or part of the device, or 3) the condition of the device or the part of the device requires repairs, and the cost of the repairs would be more than 60% of the cost of the replacement device or of the part being replaced. Confirmation from the *attending health care provider* may be required if the *prosthesis* or *orthosis* or part being replaced is less than three years old.

Amino-acid based elemental formulas are covered when *medically necessary* for conditions including but not limited to a) cystic fibrosis; b) amino acid, organic acid and fatty acid metabolic and malabsorption disorders; and c) IgE mediated allergies to food proteins, d) food protein induced enterocolitis syndrome e) eosinophilic esophagitis (EE), f) eosinophilic gastroenteritis (EG), and g) eosinophilic colitis, h) mast cell activation syndrome.

We will provide coverage for only one of the following: a manual wheelchair, a motorized wheelchair, a knee walker, or a motorized scooter, as determined by us or our designee.

Payment is limited to the most cost effective and *medically necessary* alternative. We limit coverage to the standard model, as determined by us or our designee. When you purchase a model that is more expensive than what is considered *medically necessary* by us or our designee, you will be responsible for the difference in purchase and maintenance cost. Our payment for rental shall not exceed the purchase price, unless we have determined that the item is appropriate for rental only. We reserve the right to determine if an item will be approved for rental or purchase.

If you purchase new equipment or supplies when we or our designee determines that repair costs of your current equipment or supplies would be more cost effective, then you will be responsible for the difference in cost.

Exclusions:

- a. Please see the section entitled "Exclusion List."
- b. Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage. This exclusion does not apply to certain medical supplies such as catheters and diabetic supplies. Please contact Customer Service for further assistance in determining which medical supplies are eligible for coverage under this "Durable Medical Equipment (DME) Services, *Prosthetics*, and *Orthotics*" section of this *contract*. You may also access the list of durable medical equipment, *orthoses/orthotics*, *prosthetics* and supplies (DMEPOS List) at <https://p1.aspirushealthplan.com/getting-care/medical-policy/dme/> to determine which items are eligible for coverage under this *contract*.
- c. Repair, adjustment, or replacement of parts for durable medical equipment and *prosthetics*, except when made necessary by normal wear or use.
- d. Routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of a one-month rental billed every six months.
- e. Replacement of equipment unless we determine it is *medically necessary*.
- f. Replacement of over-the-counter batteries.
- g. Duplicate or similar items.
- h. Devices and computers to assist in communication and speech.
- i. Durable medical equipment that we determine to be for your comfort, personal hygiene, or convenience including, but not limited to, personal fitness equipment and self-help devices not medical in nature.
- j. Continuous passive motion (CPM) devices and mechanical stretching devices.
- k. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs and cryotherapy; and home automated external defibrillator (AED).
- l. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
- m. Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
- n. Over-the-counter *orthotics* and appliances.
- o. Orthopedic shoes except when:
 - i. Permanently attached to a covered *orthotic* or *prosthetic* brace; or
 - ii. *Medically necessary* as therapeutic footwear for diabetics; or
 - iii. Required for a significant foot deformity where inserts alone are not sufficient.
- p. Charges for sales tax, mailing and delivery.

- q. Durable medical equipment that is necessary for the operation of other durable medical equipment which is determined to not be eligible for coverage.
- r. Durable medical equipment, *orthotics* and *prosthetics* necessary for activities beyond *activities of daily living*.
- s. Durable medical equipment, *orthotics* and *prosthetics* that *we* determine to have special features that are not *medically necessary*.
- t. Wigs, toupees, hairpieces, and cranial prothesis for conditions other than hair loss suffered as a result of illness such as alopecia areata or treatment for cancer.
- u. Hair implants, hair transplants, hair weaving, or hair loss prevention treatments.
- v. Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.
- w. Blood pressure cuffs and monitors.
- x. Enuresis alarms.
- y. Trusses.
- z. Ultrasonic nebulizers.
- aa. Oral appliances for snoring.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits, we pay:</i>
E. Emergency Services		
<i>Emergency services.</i>	80% of <i>eligible charges</i> after the deductible for <i>emergency services</i> .	80% of the <i>out-of-network rate</i> after the <i>participating provider deductible</i> for <i>emergency services</i> .
<i>Emergency services</i> provided by an immediate response service available on a 24-hour, seven-day-a-week basis for a person having a psychiatric crisis, a mental health crisis or a mental health <i>emergency</i> .	80% of <i>eligible charges</i> after the deductible for <i>emergency services</i> .	80% of the <i>out-of-network rate</i> after the <i>participating provider deductible</i> for <i>emergency services</i> .

You should be prepared for the possibility of a medical *emergency* by knowing *your participating provider's* procedures for “on call” and after regular office hours before the need arises. Determine the telephone number to call, which *hospital your participating provider* uses, and other information that will help *you* act quickly and correctly. Keep this information in an accessible location in case a medical *emergency* arises.

If *you* have an *emergency* situation that requires immediate treatment, call 911 or go to the nearest emergency facility. If possible under the circumstances, *you* should telephone the clinic where *you* normally receive care. A *physician*, physician assistant or advanced practice registered nurse will advise *you* how, when and where to obtain the appropriate treatment.

Note: Services other than *emergency services* received in an emergency room are not covered. If *you* choose to receive non-*emergency* health services in an emergency room, *you* are solely responsible for the cost of these services. See *emergency* under “Definitions.”

Notwithstanding anything in this *contract* to the contrary, Aspirus Health Plan, Inc. shall cover *emergency services*, whether provided by a *participating provider* or a *non-participating provider*, without the need for any prior authorization determination.

In the case of *emergency services* provided by a *non-participating provider*, *your deductible* and *coinsurance* will be calculated as if the total amount charged for such *emergency services* were equal to the *recognized amount*. NOTE: In no event will *your* cost-sharing requirement be greater than the cost-sharing requirement that would apply if such *emergency services* were provided by a *participating provider*.

In reviewing claims to determine if they are *emergency services* or non-*emergency services*, *we* will take the following factors into consideration: (1) whether a reasonable layperson would believe that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment; (2) the time of day and day of the week the care was provided; (3) the presenting symptoms, including, but not limited to, severe pain, to ensure that the decision to reimburse *emergency services* is not made solely on the basis of the actual diagnosis; (4) *your* efforts to follow *our* established procedures for obtaining *emergency services*; and (5) any circumstances that precluded use of the *our* established procedures for obtaining *emergency services*.

Covered services are subject to all of the benefit limitations set forth in this *contract*. *You* should provide notice to *us* of an *emergency* admission. However, if *you* are incapacitated in a manner that prevents *you* from providing notice of the admission within 48 hours, or as soon as reasonably possible, or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the 48 hour time period begins when *you* are no longer incapacitated, or when *your* parent (or guardian) is made aware of the admission. *You* are considered incapacitated only when: (1) *you* are physically or mentally unable to provide the required notice; and (2) *you* are unable to provide the notice through another person.

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. Non-*emergency services* received in an emergency room.
- c. Services received in an emergency room that do not meet the definition of *emergency medical condition* as described in Section XX. Definitions.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits:</i>
F. <i>Hearing Aids</i>		
<i>Hearing aids</i> for members with hearing loss that is not correctable by other covered procedures. Coverage limited to one <i>hearing aid</i> per ear every 3 years.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. Hearing protection equipment.
- c. *Hearing aid* batteries and cords.
- d. Over-the-counter *hearing aids*.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits:</i>
G. Home Care Services	Limited to 120 <i>home care</i> visits per <i>calendar year</i>. Limited to eight visits per <i>calendar year</i> for palliative care for <i>participating providers</i> and <i>non-participating providers</i> combined if <i>you</i> are not <i>homebound</i>. Each visit, up to 24-hours in duration, equals one visit and counts toward the maximum visits for <i>home care</i> services. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the maximum visits for <i>home care</i> services. All visits must be <i>medically necessary</i> and all charges for <i>home care</i> services must be <i>eligible charges</i> under the terms of this <i>contract</i>.	
<i>Home Care</i>	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
<i>Home Care Nursing Services</i> if <i>you</i> are currently enrolled in Medical Assistance under Minnesota Statutes Chapter 256B	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
One well-baby home visit by a registered nurse for a mother and newborn child if the inpatient <i>hospital</i> stay for the birth of the newborn was less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. This well-baby visit must occur within four calendar days after the date of the well-baby's discharge from the <i>hospital</i>. <i>Health care services</i> provided by the registered nurse may include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any <i>medically necessary</i> clinical tests.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.

We cover skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy, and other therapeutic services, laboratory services, equipment, supplies and drugs, as appropriate, and other eligible home health services prescribed by a *physician*, physician assistant or advanced practice registered nurse for the care and treatment of *your sickness* or *injury* and rendered in *your home* up to the visit limits listed above.

You must be *homebound* for care to be received in *your home*, unless *we* or *our* designee deems the care medically appropriate and/or determines that the care is more cost effective than care in a facility or clinic.

This *contract* covers *home care nursing* services in *your home*. If *you* are authorized to receive *home care nursing* services in *your home*, *you* may use approved hours outside of the home during hours when normal life activities take *you* outside of *your home*. To use *home care nursing* services at school, *you* must provide written authorization in the care plan identifying the chosen *provider* and the daily amount of services to be used at school. This *contract* does not cover *home care nursing* services for a *member* who is a resident of a *hospital*, nursing facility, intermediate care facility, or a health care facility licensed by the Commissioner of Health, unless the resident who is otherwise eligible is on leave from the facility and the facility either pays for the *home care nursing* services or forgoes the facility per diem for the leave days that *home care nursing* services are used.

Note: *Home care nursing* services do not include any such services excluded under Minnesota Statutes Sections 256B.0625, subdivision 7 and 256B.0654, subdivision 4.

A service will not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed, registered nurse. Where a service (such as a tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person, or self-administered, without the direct supervision of a licensed, registered nurse, the service will not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service does not make it a skilled service when a

skilled nurse provides it. Only the skilled nursing component of so-called “blended” services (i.e., service, that include skilled and non-skilled components) is covered.

We cover palliative care benefits if you are not homebound up to the visit limit listed above. Palliative care includes symptom management, education, and establishing goals of care.

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. Companion and *home care* services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
- c. Services provided as a substitute for a primary caregiver in the home.
- d. Services that can be performed by a non-medical person or self-administered.
- e. Services provided in *your* home for convenience.
- f. Services provided in *your* home due to lack of transportation.
- g. *Custodial care.*
- h. *Home care* services at any site other than *your* home. This exclusion does not apply to coverage for up to 120 hours of services provided by a *home care* nurse or personal care assistant to a ventilator-dependent person during the time the ventilator-dependent person is in a *hospital*.
- i. Recreational therapy.
- j. Domiciliary Care, such as meals-on-wheels, health visiting, and home help.

Benefit	Participating Provider Benefits, we pay:	Non-Participating Provider Benefits:
H. Hospice Care	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

We cover hospice services if *you* are terminally ill and accepted into a home hospice program. *You* must meet the eligibility requirements and elect to receive services through a home hospice program. The services will be provided in *your* home, with inpatient care available when *medically necessary* as described below. If *you* elect to receive hospice services, *you* do so in lieu of curative or restorative treatment for *your* terminal illness for the period *you* are enrolled in the home hospice program.

1. **Eligibility.** In order to be eligible to be enrolled in the home hospice program, *you* must:
 - a. be terminally ill with a certification from a *physician*, physician assistant, or advanced practice registered nurse that *you* have six months or less to live; and
 - b. have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than restorative treatment or treatment attempting to cure the disease or condition).

You may withdraw from the home hospice program at any time.

2. **Covered Services.** Hospice services include the following services, provided in accordance with an approved hospice treatment plan:
 - a. part-time (defined as up to two hours of service per calendar day) care in *your* home by an interdisciplinary hospice team (which might include a *physician*, nurse, social worker, and spiritual counselor or other licensed *provider*) and *home health aide services*, if prior authorized by *us* or *our* designee.
 - b. one or more periods of continuous care in *your* home or in a setting that provides day care for pain or symptom management, when *medically necessary*, as determined by *us* or *our* designee.
 - c. *medically necessary* inpatient services.
 - d. respite care for caregivers in *your* home or in an appropriate setting. Respite care should be prior authorized by *our* medical director or designee, to give *your* primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain *you* at home. Respite care is limited to five calendar days per episode and respite care and continuous care combined are limited to 30 calendar days while *you* are enrolled in the hospice program.
 - e. *medically necessary* medications for pain and symptom management, if prior authorized by *us* or *our* designee.
 - f. hospital beds and other durable medical equipment when *medically necessary* and should be prior authorized by *us* or *our* designee.

Continuous care is defined as two to 12 hours of service per calendar day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain *you* in *your* home when *you* are terminally ill.

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. *Health care services* and other services provided by *your* family or a person who shares *your* legal residence.
- c. Respite or rest care, except as specifically described in this section.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits, we pay:</i>
I. Hospital Services		
- Inpatient <i>Hospital</i> Services. - Inpatient <i>hospital</i> and <i>residential treatment facility</i> services for mental and substance use disorders.	80% of <i>eligible charges</i> after the <i>deductible</i> .	For medically necessary inpatient hospital stays that are the result of an emergency admission, until the member can be stabilized and transferred: 80% of the <i>out-of-network</i> rate after the <i>participating provider deductible</i> for <i>emergency services</i>. All other hospital services from non-participating providers: Not covered.*
- Outpatient <i>hospital</i> services, ambulatory care or surgical facility services. - Outpatient <i>hospital</i>, partial <i>hospital</i>, and rehabilitation services in a day <i>hospital</i> program for mental and substance use disorders. <i>Telehealth</i>. - Telemonitoring.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
- Diagnostic imaging, including magnetic resonance imaging and computing tomography. - Laboratory tests and pathology.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
Prenatal care except when covered as a <i>preventive health care service</i> under the “<i>Preventive Health Care Services</i>” section of this <i>contract</i>.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
<i>Medically necessary</i> genetic testing determined by <i>us</i> to be <i>covered services</i>, as described below: ✓ You display clinical features, or are at direct risk of inheriting the mutation in question (presymptomatic); and ✓ The result of the test will directly impact the current treatment being delivered to <i>you</i>; and ✓ After history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

• Nutritional counseling: ✓ Provided as outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or ✓ Provided through a <i>provider's</i> office, clinic system or <i>hospital</i> setting to a <i>member</i> who has been diagnosed with a chronic medical condition by a <i>physician</i>, physician assistant or advanced practice registered nurse; and ✓ Provided as part of the diagnosis or treatment of a mental health condition, including eating disorders, by a licensed or registered nutrition professional acting within the scope of their practice, where nutrition therapy is clinically appropriate and <i>medically necessary</i>. ✓ Not treated as a <i>preventive health care service</i>.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
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* In the case of *health care services* (other than *emergency services*) furnished by a *non-participating provider* with respect to a visit at a *hospital* or ambulatory surgical center which is a *participating provider*:

1. Unless the *non-participating provider* has satisfied the notice and consent requirements described in the section of this contract entitled “What is “**balance billing**” (sometimes called “**surprise billing**”)?”:
 - a. Your *deductible* and *coinsurance* will be calculated as if the total amount charged for such *non-emergency health care services* were equal to the *recognized amount*; and
 - b. The *coinsurance* percentage applied to such charges is 80%.
 - c. We will pay the *non-participating provider* directly for the remaining plan responsibility after your in-network cost-sharing has been applied in accordance with sections 1.a. and 1.b.
2. If the *non-participating provider* has satisfied the notice and consent requirements, then Aspirus Health Plan, Inc. will pay according to the terms of the *non-participating provider benefits* in the table above.

In the case of *emergency services* provided by a *non-participating provider*, your *deductible* and *coinsurance* will be calculated as if the total amount charged for such *emergency services* were equal to the *recognized amount*. NOTE: In no event will your cost-sharing requirement be greater than the cost-sharing requirement that would apply if such *emergency services* were provided by a *participating provider*.

Notify us of your admission to an inpatient facility within 48 hours or as soon as medically possible.

In determining maternity benefits for professional and *hospital* services for delivery and postnatal care, each *member's confinement*, including that of a newborn child, is separate and distinct from the *confinement* of any other *member*.

1. **Inpatient Services.** We cover services and supplies for the treatment of acute *sickness* or *injury* that requires the level of care only available in an *acute care facility*. Inpatient services include, but are not limited to:
 - a. room and board;

- b. the use of operating rooms, intensive care facilities, and newborn nursery facilities;
 - c. general nursing care, anesthesia, radiation therapy, physical, speech and occupational therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related *hospital* services;
 - d. *physician* and other professional medical and surgical services;
 - e. mental health and substance use disorder services, including detoxification services;
 - f. diagnostic imaging and laboratory tests and pathology; and
 - g. professional medical and surgical services provided by an assistant surgeon, which is defined as a certified physician assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant, certified registered nurse first assistant, certified nurse midwife, or a *physician*.
 - h. For a ventilator-dependent patient, up to 120 hours of services, provided by a private duty nurse or personal care assistant, solely for the purpose of communication or interpretation for the patient.
2. **Outpatient Hospital, Ambulatory Surgical Center Care, or Surgical Facility Services.** *We cover the following services and supplies, for diagnosis or treatment of sickness or injury on an outpatient basis:*
- a. use of operating rooms or other outpatient departments, rooms or facilities;
 - b. the following outpatient services: general nursing care, anesthesia, radiation therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related outpatient services;
 - c. laboratory tests, pathology and radiology;
 - d. *physician* and other professional medical and surgical services rendered while an outpatient;
 - e. mental health and substance use disorder services;
 - f. professional medical and surgical services provided by an assistant surgeon, which is defined as a certified physician assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant, certified registered nurse first assistants, certified nurse midwives, or a *physician*; and
 - g. *Medically necessary health care services*, including equipment and supplies, that are prescribed by *your provider* for the management and treatment of type I diabetes, type II diabetes, and/or gestational diabetes;
 - h. Prenatal care except when covered as a *preventive health care service* under the “*Preventive Health Care Services*” section of this *contract*.
 - i. *Telehealth* services. Any *copayment, deductible or coinsurance* payment for *health care services* provided through *telehealth* would be equal to the *copayment, deductible or coinsurance* payment of the same *health care services* provided through in-person contact.
 - j. *Telemonitoring* services. *We provide coverage for telemonitoring services if the following conditions are met:*
 - i. the telemonitoring service is medically appropriate based on the *member's* medical condition or status;
 - ii. the *member* is cognitively and physically capable of operating the monitoring device or equipment, or the *member* has a caregiver who is willing and able to assist with the monitoring device or equipment; and
 - iii. the *member* resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

We also cover preventive health care services. These services will be covered as shown in the Preventive Health Care Services, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this contract.

- 3. **Rehabilitation Services in a Day Hospital Program.** *We cover rehabilitation services in a day hospital program. Coverage is limited to services for rehabilitative care in connection with a sickness or injury.*
- 4. **Hospital or Residential Treatment Facility Care for Emotionally Disabled Children.** *We cover medically necessary inpatient treatment for emotionally disabled children as diagnosed by a physician using criteria utilized by the Minnesota Department of Human Services. This care must be authorized by and arranged through a mental health professional. For treatment provided by a hospital or residential treatment facility, inpatient coverage for emotionally disabled children is the same as the inpatient benefit. The child through age 18 years of age must be an eligible dependent according to the terms of the contract.*
- 5. **Cardiac Rehabilitation Services.** *We cover the following cardiac rehabilitation services:*
 - a. Phase I cardiac rehabilitation sessions while *you* are confined as an inpatient in a *hospital*; and
 - b. Supervised and monitored Phase II cardiac rehabilitation sessions per covered *sickness* while *you* are an outpatient receiving services in a facility with a facility-approved cardiac rehabilitation program.
- 6. **Cognitive Rehabilitation Therapy.** *We cover outpatient cognitive rehabilitation therapy following a brain injury or cerebral vascular accident.*
- 7. **Pulmonary Rehabilitation.** *We cover outpatient pulmonary rehabilitation therapy.*
- 8. **Treatment of Cleft Lip and Cleft Palate.** *We cover treatment of cleft lip and cleft palate. Treatment includes orthodontic treatment and oral surgery and dental services directly related to the cleft. If a covered member is also covered*

under a dental plan which covers orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same conditions and limitations as durable medical equipment.

9. **Court-Ordered Services.** *We* cover mental health evaluations and treatment under a valid court order when the services ordered are covered under this *contract* and:
- The court-ordered behavioral care evaluation is performed by a *participating provider* or other *provider* and the *provider* is a licensed psychiatrist, or doctoral level licensed psychologist.
 - The treatment is ordered to be provided by a *participating provider* or other *provider* as required by law and is based on a behavioral care evaluation that meets the criteria of a. above and includes a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

We must receive a copy of any court order and evaluation. *We* or *our* designee may make a motion to modify a court ordered plan and may request a new behavioral care evaluation. This court-ordered coverage must not be subject to a separate *medical necessity* determination by a health plan company under its utilization procedures.

10. **Substance Use Disorder Treatment by the Department of Corrections.** *We* cover substance use disorder treatment provided by the Department of Corrections while *you* are committed to the custody of the Department of Corrections following a conviction for first-degree driving while impaired offense under Minnesota Statute §169A.24 when the *health care services* ordered are *covered services* under this *contract* and:
- A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment that treatment may be appropriate and includes this determination as part of the sentencing order; and
 - The Department of Corrections makes a determination based on a chemical assessment conducted while *you* are in the custody of the department that treatment is appropriate.

Substance use disorder treatment provided by the Department of Corrections that meets the above requirements is not subject to a separate medical necessity determination by *us*. However, *we* must receive a copy of the court's preliminary determination and supporting documents and the assessment conducted by the Department of Corrections.

The *non-participating provider reimbursement* value for treatment provided by the Department of Corrections shall not exceed the lowest rate for outpatient chemical dependency treatment paid by *us* to a *participating provider*.

11. **Medically Necessary Hospitalization and Anesthesia for Dental Care:** This is limited to charges *incurred* by a *member* who:
- is a child under age 5; or
 - is severely disabled; or
 - has a medical condition that requires hospitalization or anesthesia for dental treatment.

Coverage is limited to facility and anesthesia charges. Oral surgeon/*dentist* or *dental specialist* professional fees are not covered for dental services provided, except as described in item 2 above. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Care must be directed by a *physician* or by a *dentist* or *dental specialist*. Coverage is subject to the exclusions found under Section IX.C. Dental Services.

12. **Gender-affirming Care.** All *medically necessary gender-affirming care* is covered subject to the terms and conditions of this *contract*.
13. **One well-baby visit** for a mother and newborn child if the inpatient *hospital* stay for the birth of the newborn was less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section.
14. **Rapid Whole Genome Sequencing (rWGS testing).** *We* cover *rWGS testing* if *you* have a complex or acute illness of unknown etiology that is not confirmed to have been caused by an environmental exposure, toxic ingestion, an infection with a normal response to therapy, or trauma; and is receiving inpatient *hospital* services in an intensive care unit or a neonatal or high acuity pediatric care unit.

rWGS testing must be *medical necessary* based on the following criteria:

- the *enrollee* has symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if *rWGS testing* is not performed;
- timely identification of a molecular diagnosis is necessary in order to guide clinical decision making, and the *rWGS testing* may aid in guiding the treatment or management of the *enrollee's* condition; and
- the *enrollee's* complex or acute illness of unknown etiology includes at least one of the following conditions:
 - congenital anomalies involving at least two organ systems, or complex or multiple congenital anomalies in one organ system;
 - specific organ malformations that are highly suggestive of a genetic etiology;
 - abnormal laboratory tests or abnormal chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism;

- iv. refractory or severe hypoglycemia or hyperglycemia;
- v. abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems;
- vi. severe muscle weakness, rigidity, or spasticity;
- vii. refractory seizures;
- viii. a high-risk stratification on evaluation for a brief resolved unexplained event with any of the following features:
- ix. a recurrent event without respiratory infection;
- x. a recurrent seizure-like event; or
- xi. a recurrent cardiopulmonary resuscitation;
- xii. abnormal cardiac diagnostic testing results that are suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease;
- xiii. abnormal diagnostic imaging studies that are suggestive of underlying genetic condition;
- xiv. abnormal physiologic function studies that are suggestive of an underlying genetic etiology; or
- xv. family genetic history related to the patient's condition.

15. **Alcoholism, mental health and substance use disorder *health care services*.** *We* will reimburse all alcoholism, mental health, and substance use disorder *health care services* provided by clinical trainees pursuant to Minnesota Statutes § 245I.04, subdivision 6, at a rate at least equal to 100 percent of the rate that would be paid to an independently licensed mental health *provider* performing the same *health care services*.

Emergency Services that Lead to an Inpatient Admission

You should provide notice to *us* of an *emergency* admission. However, if *you* are incapacitated in a manner that prevents *you* from providing notice of the admission within 48 hours or as soon as reasonably possible, or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the 48 hour time period begins when the incapacity is removed, or when *your* parent (or guardian) is made aware of the admission. *You* are considered incapacitated only when: 1) *you* are physically or mentally unable to provide the required notice; and 2) *you* are unable to provide the notice through another person.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

When coverage is applicable, under state law, health insurance issuers offering health insurance coverage as specified below may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the health insurance issuer may pay for a shorter stay if the attending *provider* (e.g., *your physician*, nurse midwife, or physician assistant), after consultation with and mutual agreement by the mother, discharges the mother or newborn earlier.

Also, health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a health insurance issuer may not require that a *physician* or other health care *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Exclusions:

- a. Please see the section entitled "Exclusion List."
- b. Travel, transportation, other than ambulance transportation, or living expenses.
- c. Non-*emergency* ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
- d. *Health care services* to treat conditions that are *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom, except for *emergency services* as required under Minnesota Statutes § 62Q.55 that are the result to complications of an excluded *cosmetic* surgery and for which coverage is provided under the "*Emergency Services*" section of this *contract*.
- e. Orthoptics and surgery for refractive conditions correctable by contacts or glasses (i.e., Lasik surgery).
- f. *Health care services* for gender reassignment, except when *medically necessary*.
- g. Genetic testing and associated *health care services*, unless *medically necessary* or as otherwise covered under the "*Hospital Services*" and "*Office Visits*" sections of this *contract*.
- h. Hypnosis.
- i. Chelation therapy, except when *medically necessary* for the treatment of heavy metal poisoning.
- j. Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- k. Autopsies.
- l. *Bariatric surgeries*, including preoperative procedures, initial procedures, surgical revisions and subsequent procedures.
- m. Services or items for personal convenience, such as television rental.
- n. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.

- o. Nutritional counseling, except as covered under the “Hospital Services,” “Office Visits,” and “*Preventive Health Care Services*” sections of this *contract*.
- p. Marital counseling, relationship counseling, family counseling or other similar counseling or training services, except as covered under the “*Hospital Services*” and “*Office Visits*” sections of this *contract*.
- q. Services to hold or confine a *member* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
- r. Counseling, studies, *confinements*, *health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by *us* or *our* designee, except as covered under this “*Hospital Services*” section of the *contract*.
- s. Nutritional and food supplements, except for folic acid as covered under the *Preventive Health Care Services* Schedule and amino acid based elemental formulas as covered under the “Durable Medical Equipment (“DME”) Services, *Prosthetics*, and *Orthotics*” section of this *contract*.
- t. Cardiac rehabilitation beyond Phase II.
- u. *Biofeedback* received in a hospital setting.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits, we pay:</i>
J. Infertility Services		
Diagnostic services.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Same as the <i>participating provider benefits</i> . Please see section IX.S. “Specified <i>Non-Participating Provider Services</i> ” for <i>non-participating provider benefits</i> for <i>provider visits</i> and tests necessary to make a diagnosis of <i>infertility</i> .
Treatment to correct underlying causes of <i>infertility</i> .	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

We cover professional services necessary to diagnose *infertility* and the related tests, facility charges, and laboratory work related to the diagnosis. We also cover *health care services* required to treat or correct the underlying causes of *infertility* (e.g. blocked fallopian tube, endometriosis).

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. Reversal of voluntary sterilization.
- c. Adoption costs.
- d. *Health care services* associated with expenses for *infertility*, including assisted reproductive technology, except for those services related to a covered medical condition.
- e. Direct attempts to achieve pregnancy or increase chances of pregnancy by any means.
- f. Any laparoscopic procedure during which an ovum is manipulated for the purpose of *fertility treatment* even if the laparoscopic procedure includes other purposes.
- g. Gamete intrafallopian transfer (GIFT) procedures.
- h. Zygote intrafallopian transfer (ZIFT) procedures.
- i. Intracytoplasmic sperm injection (ICSI).
- j. In-vitro fertilization.
- k. *Health care services* related to surrogate pregnancy for a person who is not a *member* under this *contract*.
- l. Artificially assisted technology, such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
- m. Sperm, ova or embryo acquisition, retrieval or storage.
- n. *Prescription drugs* for which the primary purpose is to preserve fertility.

Benefit	Participating Provider Benefits, we pay:	Non-Participating Provider Benefits, we pay: Note: For non-participating providers, in addition to any <i>deductible</i> and <i>coinsurance</i> , you pay all charges that exceed the non-participating provider reimbursement value.
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K. Office Visits		
<i>Sickness or injury</i> – Primary care, <i>specialist</i> and other practitioner (nurse, <i>physician</i>) office visits related to diagnosis, care or treatment of a medical, mental health or substance use related condition. <i>Telehealth</i>. - Telemonitoring. - Allergy visits. Note: Some services that may be provided during an office visit may be subject the <i>deductible</i>, such as, but not limited to, laboratory, pathology, radiology, surgical procedures, and allergy testing and injections.	Primary Care*: 100% of <i>eligible charges</i> for the first four primary care office visits per member per calendar year. Thereafter: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$30 per visit. <i>Deductible</i> does not apply. Specialist: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$70 per visit. <i>Deductible</i> does not apply.	Not covered.
- Diagnostic imaging, including magnetic resonance imaging and computing tomography. - Laboratory tests and pathology.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
Surgical Services.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
<i>Virtual Care.*</i>	100% of <i>eligible charges</i> for the first four primary care office visits per member per calendar year. Thereafter: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$20 per visit. <i>Deductible</i> does not apply.	Not covered.
<i>Convenience Care Center.</i>	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
<i>Urgent Care Center.</i> Note: Some services that may be provided during an <i>urgent care center</i> visit may be subject to the <i>deductible</i>, such as, but not limited to, laboratory, pathology, and radiology testing and surgical procedures.	100% of <i>eligible charges</i> after a <i>copayment</i> of \$55 per visit. <i>Deductible</i> does not apply.	Not covered.
Allergy injections with no office visit.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

• Port wine stain elimination or maximum feasible treatment to lighten or remove the discoloration.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
• Nutritional counseling*: ✓ Provided as outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or ✓ Provided through a <i>provider's</i> office, clinic system or <i>hospital</i> setting to a <i>member</i> who has been diagnosed with a chronic medical condition by a <i>physician</i>, physician assistant or advanced practice registered nurse; and ✓ Provided as part of the diagnosis or treatment of a mental health condition, including eating disorders, by a licensed or registered nutrition professional acting within the scope of their practice, where nutrition therapy is clinically appropriate and <i>medically necessary</i>. ✓ Not treated as a <i>preventive health care service</i>.	100% of <i>eligible charges</i> for the first four primary care office visits per <i>member</i> per <i>calendar year</i> . Thereafter: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$30 per visit. <i>Deductible</i> does not apply.	Not covered.
• <i>Comprehensive postnatal visits</i>. *	100% of <i>eligible charges</i> for the first four primary care office visits per <i>member</i> per <i>calendar year</i> . Thereafter: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$30 per visit. <i>Deductible</i> does not apply.	Not covered.

• <i>Medically necessary</i> genetic testing determined by <i>us</i> to be <i>covered services</i>, as described below: ✓ <i>You</i> display clinical features, or are at direct risk of inheriting the mutation in question (presymptomatic); and ✓ The result of the test will directly impact the current treatment being delivered to <i>you</i>; and ✓ After history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
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*Note: Four primary care office visits per *calendar year* at a *participating provider* are free, then *deductible* and *coinsurance* apply. This coverage includes primary care office visits, *virtual care* visits, and *telehealth* visits that are considered primary care.

We cover the professional medical and surgical services of licensed *physicians*, physician assistants, advanced practice registered nurses, and other health care *providers* and nurses.

- Services are provided for the following:
 - Office visits relating to the diagnosis, care or treatment of a condition, *sickness* or *injury*.
 - Treatment of diagnosed Lyme disease.
 - Contact lenses and their related fittings are ineligible for coverage when received after the end of the year in which *you* turn 19, unless such lenses are prescribed as *medically necessary* for the treatment of keratoconus. If prescribed for keratoconus, *your* first set of contact lenses and their fitting are *eligible charges* under the DME benefit. *You* must pay for lens replacement.
 - Diagnostic imaging (such as x-rays, CT/PET scans, MRIs), laboratory tests, and pathology.
- Outpatient professional services for evaluation, diagnosis, crisis intervention, therapy, including *medically necessary* group therapy, psychiatric services, treatment of a minor (including family therapy but only for treatment of a minor), and treatment of mental and nervous disorders.
- Diagnosis and treatment of substance use disorders, including evaluation, diagnosis, therapy and psychiatric services.
- Alcoholism, mental health and substance use disorder *health care services*. *We* will reimburse all alcoholism, mental health, and substance use disorder *health care services* provided by clinical trainees pursuant to Minnesota Statutes § 245I.04, subdivision 6, at a rate at least equal to 100 percent of the rate that would be paid to an independently licensed mental health *provider* performing the same *health care services*.
- Port wine stain elimination or maximum feasible treatment to lighten or remove discoloration.
- Allergy testing and injections.
- Surgical services performed in the office, including but not limited to:
 - Oral surgery* for: 1) treatment of oral neoplasms and non-dental cysts; 2) fracture of the jaws; and 3) trauma of the mouth and jaws.
 - Surgical and non-surgical treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD) that is *medically necessary*.
- Treatment of diagnosed diethylstilbestrol (DES) exposure.
- Diabetic outpatient self-management training and education, including medical nutrition therapy received from a *provider* working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.
- An *emergency* examination of a child ordered by judicial authorities.

11. Court-Ordered Services. *We* cover mental health evaluations and treatment under a valid court order when the services ordered are covered under this *contract* and:
 - a. The court-ordered behavioral care evaluation is performed by a *participating provider* or other *provider* as required by law and the *provider* is a licensed psychiatrist, or doctoral level licensed psychologist.
 - b. The treatment is provided by a *participating provider* or other *provider* as required by law and is based on a behavioral care evaluation that meets the criteria of a. above and includes a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

We must receive a copy of any court order and evaluation. *We* or *our* designee may make a motion to modify a court ordered plan and may request a new behavioral care evaluation. This court-ordered coverage must not be subject to a separate *medical necessity* determination by a health plan company under its utilization procedures.

12. Telehealth Services. Any *copayment, deductible* or *coinsurance* payment for *health care services* provided through *telehealth* would be equal to the *copayment, deductible* or *coinsurance* payment of the same *health care services* provided through in-person contact.
13. Telemonitoring Services. *We* provide coverage for telemonitoring services if the following conditions are met:
 - a. the telemonitoring service is medically appropriate based on the *member's* medical condition or status;
 - b. the *member* is cognitively and physically capable of operating the monitoring device or equipment, or the *member* has a caregiver who is willing and able to assist with the monitoring device or equipment; and
 - c. the *member* resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.
14. Treatment of Cleft Lip and Cleft Palate. *We* cover treatment of cleft lip and cleft palate. Treatment includes orthodontic treatment, *oral surgery* and dental services directly related to the cleft. If a covered *member* is also covered under a dental plan which covers orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same conditions and limitations as durable medical equipment.
15. Substance Use Disorder Treatment by the Department of Corrections. *We* cover substance use disorder treatment provided by the Department of Corrections while *you* are committed to the custody of the Department of Corrections following a conviction for first-degree driving while impaired offense under Minnesota Statutes §169A.24 when the *health care services* ordered are *covered services* under this *contract* and:
 - a. A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment that treatment may be appropriate and includes this determination as part of the sentencing order; and
 - b. The Department of Corrections makes a determination based on a chemical assessment conducted while *you* are in the custody of the department that treatment is appropriate.

Substance use disorder treatment provided by the Department of Corrections that meets the above requirements is not subject to a separate medical necessity determination by *us*. However, *we* must receive a copy of the court's preliminary determination and supporting documents and the assessment conducted by the Department of Corrections.

The *non-participating provider reimbursement* value for treatment provided by the Department of Corrections shall not exceed the lowest rate for outpatient chemical dependency treatment paid by *us* to a *participating provider*.

16. Biofeedback.
17. *Medically necessary health care services*, including equipment and supplies, that are prescribed by *your provider* for the management and treatment of type I diabetes, type II diabetes, and/or gestational diabetes.
18. Treatment for *pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)* and for *pediatric acute-onset neuropsychiatric syndrome (PANS)*, including but not limited to behavioral therapies to manage neuropsychiatric symptoms.
19. Prenatal care except when covered as a *preventive health care service* under the “Preventive Health Care Services” section of this *contract*.
20. Postnatal care, including:
 - a. a *comprehensive postnatal visit* with a health care *provider* not more than three weeks from the date of delivery;
 - b. any postnatal visits recommended by a health care *provider* between three and 11 weeks from the date of delivery; and
 - c. a *comprehensive postnatal visit* with a health care *provider* 12 weeks from the date of delivery.
21. One well-baby visit for a mother and newborn child if the inpatient *hospital* stay for the birth of the newborn was less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section.
22. *Rare Diseases*. Services received from a *non-participating provider* for services related to the diagnosis, monitoring, and treatment of a *rare disease* will be treated as in-network services. *You* may be responsible for additional expenses when services are received outside of Minnesota. This benefit does not apply to drugs received from a retail pharmacy. If *you* are later

definitively diagnosed with a disease or condition that is not a *rare disease*, you must notify us. We will assist you in making the transition from *non-participating provider* to a *participating provider*. When it is determined you do not have a *rare disease*, coverage will continue at in-network benefits for 60 days. After this 60-day period, services from a *non-participating provider* will be covered at out-of-network benefits.

23. We cover biomarker testing to diagnose, treat, manage and monitor illness or disease when the test provides clinical utility. A test's clinical utility may be demonstrated by medical and scientific evidence as explained in Minn. Stat. Ann. § 62Q.473.
24. *Gender-affirming Care*. All *medically necessary gender-affirming care* is covered subject to the terms and conditions of this *contract*.

We also cover *preventive health care services*. These services will be covered as shown in the *Preventive Health Care Services*, and/or the *Preventive Contraceptive Methods and Counseling for Women* sections of this *contract* and not this section of the *contract*.

Exclusions:

- a. Please see the section entitled Exclusion List.
- b. Health education, except when:
 - i. Provided during an office visit for *non-preventive health care services*; or
 - ii. It is counseling that is treated as a *preventive health care service*.
- c. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
- d. Nutritional counseling, except as covered under the “Hospital Services,” “Office Visits,” and “Preventive Health Care Services” sections of this *contract*.
- e. Marital counseling, relationship counseling, family counseling, or other similar counseling or training services, except as covered. under the “Hospital Services” and “Office Visits” sections of this *contract*.
- f. Professional sign language and foreign language interpreter services in a *provider’s* office.
- g. Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or treated as a *preventive health care service*.
- h. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by us or our designee.
- i. Genetic testing and associated *health care services*, unless *medically necessary* or as otherwise covered under the “Hospital Services” and “Office Visits” sections of this *contract*.
- j. Hypnosis.
- k. Chelation therapy, except when *medically necessary* for the treatment of heavy metal poisoning.
- l. Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- m. Vision therapy/orthoptics.
- n. Counseling, studies, *confinements*, *health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by us or our designee, except as covered under this “Office Visits” section of the *contract*.
- o. Nutritional and food supplements, except for folic acid as covered under the *Preventive Health Care Services* schedule and amino acid-based elemental formulas and enteral feedings as covered under the “Durable Medical Equipment (“DME”) Services, *Prosthetics*, and *Orthotics*” section of this *contract*.
- p. *Conversion therapy*.

Benefit	<i>Designated Transplant Network Provider, we pay:</i>	<i>Non-Designated Transplant Network Provider</i>
L. Organ and Bone Marrow Transplant Services	Office Visits: See the “Office Visits” section of this <i>contract</i> . Hospital Services: See the “Hospital Services” section of this <i>contract</i> .	Not covered.

We cover eligible *transplant services* that we or our designee determine to be *medically necessary* and not *investigative* but only when the *transplant services* are received at a *designated transplant network provider*. Prior Authorization by us or our designee is required in advance of receiving *transplant services*.

Coverage for organ transplants, bone marrow transplants, and bone marrow rescue services is subject to periodic review. We evaluate *transplant services* for therapeutic treatment and safety. This evaluation continues at least annually, or as new information becomes available, and it results in specific guidelines about benefits for *transplant services*. You may call Customer Service at the telephone number listed inside the cover of this *contract* for information about these guidelines.

If the transplant meets the definition of an *eligible charge*, is *medically necessary*, and is not *investigative*, benefits are available for the following eligible transplants:

1. Bone marrow transplants and peripheral stem cell transplants.
2. Heart transplants.
3. Heart/lung transplants.
4. Lung transplants.
5. Kidney transplants.
6. Kidney/pancreas transplants.
7. Liver transplants.
8. Pancreas transplants.
9. Small bowel transplants.
10. Cornea transplants.
11. Artificial or mechanical devices, if approved as a bridge to a transplant or destination therapy.

Transplant coverage includes a private room and all related post-surgical treatment and drugs. The transplant-related treatment provided shall be subject to and in accordance with the provisions, limitations, and other terms of this *contract*.

Medical and *hospital* expenses of the donor are covered only when the recipient is a *member*. Treatment of medical complications that may occur to the donor are not covered. Prior authorization by us or our designee is required for *transplant services*.

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. *Transplant services* received from a *provider* that is not a *designated transplant network provider*.
- c. *Health care services* related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are *investigative* for your diagnosis or condition.
- d. *Health care services*, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by us or our designee.
- e. *Health care services*, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.
- f. Non-emergency ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
- g. Treatment of medical complications to a donor after procurement of a transplanted organ.
- h. Computer search for donors.
- i. Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
- j. Travel expenses related to a covered transplant.
- k. *Health care services* for or in connection with fetal tissue transplantation, except for non-*investigative* stem cell transplants.

1. Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of US Food and Drug Administration (FDA) approved ventricular assist devices and transplants of artificial or mechanical devices as a bridge to a transplant or destination therapy.

Benefit	Participating Provider Benefits, we pay:	Non-Participating Provider Benefits:
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M. Physical Therapy, Occupational Therapy and Speech Therapy		
- Physical therapy for <i>habilitative care</i>. - Physical therapy for <i>rehabilitative care</i>.	100% of <i>eligible charges</i> after a <i>copayment</i> of \$35 per visit. <i>Deductible</i> does not apply.	Not covered.
- Occupational therapy for <i>habilitative care</i>. - Occupational therapy for <i>rehabilitative care</i>.	100% of <i>eligible charges</i> after a <i>copayment</i> of \$35 per visit. <i>Deductible</i> does not apply.	Not covered.
- Speech therapy for <i>habilitative care</i>. - Speech therapy for <i>rehabilitative care</i>.	100% of <i>eligible charges</i> after a <i>copayment</i> of \$35 per visit. <i>Deductible</i> does not apply.	Not covered.

We cover office visits and outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for *rehabilitative care* rendered to treat a medical condition, *sickness* or *injury*, and the *rehabilitative care* is expected to demonstrate measurable and sustainable improvement within 2 weeks to 3 months, depending on the physical and mental capacities of the individual. We also cover office visits and outpatient PT, OT and ST *habilitative* therapy for medically diagnosed conditions. PT, OT and ST must be provided by or under the direct supervision of a licensed physical therapist, occupational therapist or speech therapist for appropriate services within their scope of practice. OT and ST must be ordered by a *physician*, physician assistant or advanced practice registered nurse.

Note: Benefits for *health care services* administered or received in an inpatient setting are described in the “*Hospital Services*” section of this *contract*. Benefits for *skilled care* administered or received in a *skilled nursing facility* are described in the “*Skilled Care Services*” section of this *contract*.

Exclusions:

- Please see the section entitled “Exclusion List.”
- Custodial care* or *maintenance care*.
- Therapy provided in *your* home for convenience.
- Therapy for conditions that are self-correcting.
- Voice training and voice therapy absent a medical condition.
- Investigative* therapies.
- Group therapy for physical therapy, occupational therapy and speech therapy.
- Health care services* for homeopathy and immunoaugmentive therapy.

Benefit	Drugs obtained at a pharmacy that is a <i>participating provider</i>, we pay:
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N. Prescription Drug Services

Please see the *Preventive Health Care Services* section for coverage of *prescription drugs*, including certain insulin and other glucose lowering agents, on *our* Preventive Drug List.

Prescription drugs are not covered if obtained from a pharmacy that is not a participating provider.

• <i>Prescription drugs</i> that can be self-administered and supplies dispensed by a participating pharmacy for up to a 90-calendar day supply per prescription or refill, except for <i>prescription drugs and related medical supplies</i> prescribed to treat a <i>chronic disease</i>. • Diabetic Supplies. Coverage includes over-the-counter diabetic supplies, glucose monitors, syringes, blood and urine test strips, and other diabetic supplies as <i>medically necessary</i> for up to a 90-calendar day supply per prescription or refill, except for <i>prescription drugs and related medical supplies</i> prescribed to treat a <i>chronic disease</i>.	<u>Up to a 30-day Supply</u> Generic: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$15 per prescription or refill. <i>Deductible</i> does not apply. Preferred Brand: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$30 per prescription or refill. <i>Deductible</i> does not apply. Non-Preferred Brand: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$90 per prescription or refill. <i>Deductible</i> does not apply. Non-Formulary: Not covered, unless a formulary exception is granted. <u>31-90 day Supply</u> Generic: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$37.50 per prescription or refill. <i>Deductible</i> does not apply. Preferred Brand: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$75 per prescription or refill. <i>Deductible</i> does not apply. Non-Preferred Brand: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$225 per prescription or refill. <i>Deductible</i> does not apply. Non-Formulary: Not covered, unless a formulary exception is granted.
<i>Prescription drugs and related medical supplies</i> prescribed to treat a <i>chronic disease</i>	100% of <i>eligible charges</i> after a <i>copayment</i> of \$25 per one-month supply for each <i>prescription drug</i>, regardless of the amount or type of medication required to fill the prescription; and \$50 per month in total for all related medical supplies. The cost-sharing limit for <i>related medical supplies</i> does not increase with the number of <i>chronic diseases</i> for which the <i>enrollee</i> is treated. Coverage under this section shall not be subject to any <i>deductible</i>.

• Mail order <i>prescription drugs</i> and supplies dispensed by a participating pharmacy for up to a 90-calendar day supply per prescription or refill, except for <i>prescription drugs and related medical supplies</i> prescribed to treat a <i>chronic disease</i>. • Mail Order Diabetic Supplies. Coverage includes over-the-counter diabetic supplies, glucose monitors, syringes, blood and urine test strips, and other diabetic supplies as <i>medically necessary</i> for up to a 90-calendar day supply per prescription or refill, except for <i>prescription drugs and related medical supplies</i> prescribed to treat a <i>chronic disease</i>.	<u>Up to a 30-day Supply</u> Generic: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$15 per prescription or refill. <i>Deductible</i> does not apply. Preferred Brand: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$30 per prescription or refill. <i>Deductible</i> does not apply. Non-Preferred Brand: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$90 per prescription or refill. <i>Deductible</i> does not apply. Non-Formulary: Not covered, unless a formulary exception is granted. <u>31-90 day Supply</u> Generic: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$37.50 per prescription or refill. <i>Deductible</i> does not apply. Preferred Brand: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$75 per prescription or refill. <i>Deductible</i> does not apply. Non-Preferred Brand: 100% of <i>eligible charges</i> after a <i>copayment</i> of \$225 per prescription or refill. <i>Deductible</i> does not apply. Non-Formulary: Not covered, unless a formulary exception is granted.
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Specialty Drugs		
Benefit	Specialty Drugs obtained at our designated specialty pharmacy, we pay: For more information, contact Customer Service.	Specialty Drugs obtained at any pharmacy other than a designated specialty pharmacy:
<i>Specialty drugs</i> are covered at the <i>specialty drug</i> benefit level regardless of whether the <i>specialty drug</i> is otherwise classified as a generic or a brand name drug. Benefits for <i>specialty drugs</i> are as described in this section regardless of the place of service where the <i>specialty drug</i> is dispensed or administered. Note: Certain <i>specialty drugs</i> may only be available by limited distribution through the manufacturer's select specialty pharmacy and may not be available through <i>our</i> designated specialty pharmacy. Benefits for such limited distribution <i>specialty drugs</i> will be paid the same as if they were obtained from <i>our</i> designated specialty pharmacy.		

<i>Specialty drugs</i> up to a 30–calendar day supply per prescription or refill that: ✓ may be oral or injectable; and ✓ must be purchased through a specialty pharmacy. A list of these <i>specialty drugs</i> may be obtained on the designated website or by calling Customer Service. The list of <i>specialty drugs</i> may be revised from time-to-time without notice.	100% of <i>eligible charges</i> after a <i>copayment</i> of \$360 per prescription or refill. <i>Deductible</i> does not apply. Non-Formulary: Not covered, unless a formulary exception is granted.	Not covered.
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Preventive Contraceptives. This section does not cover or provide benefits for oral, injectable, insertable *prescription drugs* and devices that are *preventive health care services* described in the “Preventive Contraceptive Methods and Counseling for Women” section of this *contract*.

Formulary. We use a drug *formulary* to determine which benefit level applies to a specific *prescription drug*. The *formulary* is subject to periodic review by *our* Pharmacy and Therapeutics Quality Subcommittee and modification by *us*, including at the start of or during the plan year. A current list of drugs on *our formulary* for individual plans may be obtained by accessing *our* website at <https://www.aspirushealthplan.com> or by calling Customer Service. We will provide reasonable advance notice to *you* if, during the plan year, a *prescription drug* which *you* have previously received during such plan year and which *we* have previously considered to be an *eligible charge* under this *contract* is removed from the *formulary* or if such *prescription drug* is placed in a higher cost-sharing tier during the plan year. *You* have a right to appeal the decision or to request an exception to gain access to a non-formulary drug when clinically appropriate and not otherwise covered under this *contract*. Refer to the section entitled “Internal Appeals Process” for details on how to appeal. Refer to the paragraphs entitled “Exceptions” below for details on how to request an exception.

Step Therapy. For certain medical conditions, there is a need to manage the use of specific drugs before alternative (second line) drugs are prescribed for the same medical condition. This is known as step therapy. *Members* in a step therapy program will need to meet the requirements of that program prior to receiving the second line drug. If *we* require that *you* follow a step therapy protocol, *you* may request to override this process if certain conditions apply. *You* may learn more about the program requirements on *our* website or by calling Customer Service. Step therapy can apply to *formulary* or non-formulary drugs. Step therapy can also apply, regardless of tier, to generic, preferred brand, non-preferred brand, or *specialty drugs*. The Step Therapy List is subject to periodic review and modification by *us*. At *your* written request, *we* will provide *you* the criteria that *we* use to determine the *medical necessity* and appropriateness of a *prescription drug* that is subject to step therapy. *We* shall respond to a step therapy override request or an appeal within five days of receipt of a complete request. In cases where exigent circumstances exist, *we* shall respond within 72 hours of receipt of a complete request. If *we* do not respond within this timeline, the override request of appeal is granted and binding on *us*.

Any coverage for the treatment of stage four advanced metastatic cancer or associated conditions does not limit or exclude coverage for a drug approved by the United States Food and Drug Administration that is on *our prescription drug formulary* by

mandating that an *enrollee* with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

1. a United States Food and Drug Administration-approved indication; and
2. a clinical practice guideline published by the National Comprehensive Care Network.

Quantity Limits. Some dispensed *prescription drugs* require the use of quantity limits, which ensure that the quantity of each prescription remains consistent with clinical guidelines. Quantity limits can apply to *formulary* or non-*formulary* drugs. Quantity limits can also apply, regardless of tier, to generic, preferred brand, non-preferred brand, or *specialty drugs*. A list of those *prescription drugs* with quantity limits is available upon request. The quantity limits list is subject to periodic review and modification by *us*.

Eye Drop Refills. Refills of prescribed eye drops are covered if the refill is requested by the *member* covered under this *contract* and the prescribing *provider* indicates that refills are required. Coverage for such eye drops will only be provided if *you* make a refill request for a 30-day refill supply and the request is made between 21 and 30 days from the later of the original date the prescription was dispensed or the date of the most recent refill. Coverage for such eye drops will only be provided if *you* make a refill request for a 90-day refill supply and the request is made between 75 and 90 days from the later of the original date the prescription was dispensed or the date of the most recent refill.

Biosimilar Drugs. If all of the following apply:

1. *You* or *your provider* request a *specialty drug* that is a biological product licensed by the FDA under section 351(a) of the Public Health Service Act (PHS Act), and
2. The FDA has determined another biological product to be biosimilar to the *specialty drug* that has been requested by *your provider*, and
3. *We* have included such biosimilar product on *our* list of approved biosimilar drugs in relation to the *specialty drug* that has been requested by *your provider*,

then *you* must pay the applicable *deductible* and *coinsurance* for the *specialty drug* requested by *your provider* plus the difference in cost between the *specialty drug* requested by *your provider* and the biosimilar product that is on *our* list of approved biosimilar drugs.

Brand Name Drugs for which a Generic Available. Except as provided in the “Preventive Contraceptive Methods and Counseling For Women” section of this *contract*, if *you* request a brand name drug when a generic drug alternative is available, *you* must pay the applicable preferred brand or non-preferred brand *copayment*, *deductible* and *coinsurance* for the brand name drug plus the difference in cost between the brand name and the generic drug.

Formulary Exceptions: *You* or *your provider* may request an exception to the drug *formulary*. *We* must make a determination on a standard exception request and notify *you* and the prescribing *physician* of *our* coverage determination no later than 72 hours following receipt of the request. Upon request, *we* will perform an expedited review of the exception request if *you* are suffering from a health condition that may seriously jeopardize *your* life, health, or ability to regain maximum function, or when *you* are undergoing a current course of treatment using a non-*formulary* drug. If *we* determine *you* qualify for an expedited review of the exception request based on these criteria, *we* must make a determination on the expedited exception request and notify *you* and the prescribing *physician* of *our* coverage determination no later than 24 hours following receipt of the request. *We* will determine if an exception applies and, if so, the non-*formulary* drugs that are approved as an exception will be covered at the same level as the *formulary* drugs.

If *your* request for a *formulary* exception is denied, *you* have a right to request that *your formulary* exception request be reviewed by an independent review organization that is not associated with *us*. This right to request external review of a *formulary* exception request is separate from *your* right to request external review as described in the External Review Process section and only applies to denials of a *formulary* exception request and only after *your formulary* exception request has been reviewed in accordance with the preceding paragraph and denied. When *you* request an external review of a *formulary* exception request, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision. If *your formulary* exception request is complete and eligible for external review, *we* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization. If the original *formulary* exception request was a standard exception request, *you* will be notified of the results of the external review within 72 hours following receipt of the request. If the original *formulary* exception request was an expedited exception request, *you* will be notified of the results of the external review within 24 hours following receipt of the request.

An exception is valid for the duration of the prescription while covered under this *contract*, including refills, except that if *you* obtained an exception based on an expedited review the exception will be valid for the duration of the circumstances that are the basis for the expedited review. *Your physician* may request the exception for subsequent prescriptions, following the procedure described above. The exception does not apply if *we* removed the drug from the *formulary* for safety reasons. Contact Customer Service for a copy of the written guidelines and procedures, or for assistance in requesting an exception.

Antipsychotic Drugs

Required coverage for antipsychotic drugs. An antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the *prescription drug* is in the health plan's formulary, if the *provider* prescribing the *prescription drug*:

1. indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated; and
2. certifies in writing to Aspirus Health Plan, Inc. that the *provider* has considered all equivalent *prescription drug* in the formulary and has determined that the *prescription drug* prescribed will best treat the *member's* condition.
 - a. We will not cover such a *prescription drug* if the *prescription drug* was removed from the formulary for safety reasons.
 - b. For a *prescription drug* covered under this section, if Aspirus Health Plan, Inc. has received a certification from the *provider* as described in paragraph (a), we:
 - i. will cover the *prescription drug* with the same *member* cost-sharing as would apply to a prescription drug in the same benefit class (i.e. generic, preferred brand, or non-preferred brand name) on our *prescription drug* formulary.
 - ii. will not require written certification from the prescribing *provider* each time a prescription is refilled or renewed that the *prescription drug* prescribed will best treat the *member's* condition.

Continuing care.

If you are receiving a *prescription drug* to treat a diagnosed mental illness or emotional disturbance, you may continue to receive the *prescription drug* for up to one year with the same *member* cost-sharing as would apply to a prescription drug in the same benefit class (i.e. generic, preferred brand, or non-preferred brand name) on our *prescription drug* formulary. If we change our *prescription drug* formulary, or if you change to a different health insurer's coverage, and the *prescription drug* has been shown to effectively treat your condition, then in order to be eligible for this continuing care benefit:

1. You must have been treated with the *prescription drug* for 90 days prior to the change in our *prescription drug* formulary or your change to a different health insurer's coverage;
2. Your *provider* who prescribed the drug indicates to the dispensing pharmacist, orally or in writing that the *prescription drug* must be dispensed as communicated; and
3. Your *provider* who prescribed the drug certifies in writing to us that the *prescription drug* will best treat your condition.

This continuing care benefit shall be extended annually when the *provider* who prescribed the drug:

1. indicates to the dispensing pharmacist, orally or in writing, that the *prescription drug* must be dispensed as communicated; and
2. certifies in writing to us that the *prescription drug* will best treat your condition.

However, we will not provide coverage for a *prescription drug* if the drug was removed from the formulary for safety reasons.

Compounded Drugs. *Compounded drugs* will be covered provided that at least one active ingredient is a *prescription drug*. Payment for a *compounded drug* that has a commercially prepared product available that is identical to or similar to the *compounded drug* will be considered for coverage after documented failure of the commercially prepared product(s), unless a *formulary* exception is obtained. A commercially prepared product is one that is available at the pharmacy in its final, usable form and does not need to be compounded at the pharmacy. Non-preferred brand *formulary* benefits apply. *Compounded drugs* containing any product that is excluded by us will not be covered, including dosages and route of administration that have not been approved by the FDA.

Prescription Drugs covered as Preventive Health Care Services. We cover certain *prescription drugs* which are required to be covered without cost-sharing as *preventive health care services* under the *Affordable Care Act*. Our *formulary* identifies these *prescription drugs* as "Preventive". The *formulary* may be obtained by accessing our website at www.aspirushealthplan.com or by calling Customer Service. More information regarding benefits for *prescription drugs* that are *preventive health care services* can be found under the "Preventive Contraceptive Methods and Counseling for Women" and "Preventive Health Care Services" sections of this *contract*.

Off-label use of drugs. Off-label use of drugs, provided they are not *investigative*, are covered when:

1. A drug is recognized as appropriate for cancer treatment in a *standard reference compendia* such as the National Comprehensive Cancer Network Drugs and Biologics Compendium or one article in the *medical literature*; or
2. A drug is deemed appropriate for its proposed use by any authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case-reports.

Cancer Chemotherapy. We will not require a higher *deductible* or *coinsurance* amount for an anticancer *prescription drug* used to kill or slow the growth of cancerous cells that is orally-administered than for an anticancer *prescription drug* that is injected or intravenously-administered.

PANDAS/PANS. We cover treatment for *pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)* and for *pediatric acute-onset neuropsychiatric syndrome (PANS)*, including but not limited to antibiotics, medication to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

Opiate Antagonists. We cover opiate antagonists for the treatment of an acute opiate overdose prescribed by a *physician*, physician assistant, advanced practice registered nurse or a licensed pharmacist.

Emergency Prescription Drug Refills: We cover an emergency refill of a *prescription drug* dispensed by a pharmacist under Minnesota Statutes § 151.211 the same as if the *prescription drug* had been dispensed according to a prescription.

Gender-affirming Care. All *medically necessary prescription drugs* for *gender-affirming care* are covered subject to the terms and conditions of this *contract*.

Optum Copay Card Solutions: Aspirus Health Plan, Inc. utilizes Optum Copay Card Solutions to obtain *prescription drug* manufacturer discounts on *your* behalf. If a manufacturer copay card is available, *you* have the option to enroll with the manufacturer and use the card towards payment of *your prescription drugs*. Amounts paid by manufacturers on *your* behalf under a copay card program, along with other payments from manufacturers, such as manufacturer coupons, will be used to satisfy *your copayment, deductible or out-of-pocket limit* only if the prescription brand name drug does not have an available and medically appropriate generic equivalent.

However, if this *contract* is a High Deductible Health Plan (HDHP) which *you* have paired with a Health Savings Account (HSA), any such amounts paid by manufacturers will not be applied to *your subscriber-only or family deductible*, whichever is applicable, or any other cost-sharing amounts prior to such *deductible* being satisfied, but any such amounts paid by manufacturers will be applied to *your subscriber-only or family out-of-pocket limit*, whichever is applicable, after such *deductible* is satisfied.

If *you* do not enroll in an available copay card program, *you* will be responsible for all out-of-pocket costs associated with receiving the *prescription drug* as per *your* plan benefit. Call Customer Service for additional information.

Optum Variable Copay Program: We work with Optum to process copay assistance cards on *your* behalf. This program applies to certain *prescription drugs* that have manufacturer-funded copay assistance programs available.

Under the Optum Variable Copay program, if the *prescription drug* has copay assistance available, the amount *you* pay for select medications may be set to the maximum of the current benefit design, \$0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, *you* will be required to remain enrolled in the program for obtaining manufacturer assistance. Amounts paid by manufacturers on *your* behalf under the variable copay program, along with other payments from manufacturers, such as manufacturer coupons, will be used to satisfy *your copayment, deductible or out-of-pocket limit* only if the prescription brand name drug does not have an available and medically appropriate generic equivalent.

Prior Authorization. Certain *prescription drugs* may require prior authorization before *you* can have *your* prescription filled at the pharmacy. These *prescription drugs* may include, but are not limited to:

1. *Compounded drugs* that are over \$200;
2. *Specialty drugs*; and
3. Other *prescription drugs* listed on the *formulary* as requiring prior authorization.

For more information, please call the phone number listed on the inside front cover of this *contract*.

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. *Prescription drugs* obtained from a pharmacy that is a *non-participating provider*.
- c. Replacement of a *prescription drug* due to loss, damage, or theft.
- d. Drugs available over-the-counter (OTC), except prescribed OTC drugs that are required to be covered as *preventive health care services* under the *Affordable Care Act* as covered under the “Preventive Contraceptive Methods and Counseling for Women” or “Preventive Health Care Services” sections of this *contract*.
- e. *Prescription drugs* equivalent to or similar to OTC drugs, except as provided in the drug *formulary*.
- f. OTC home testing products, except diabetic supplies, glucose monitors and blood and urine test strips for diabetes, or as otherwise covered under state or federal law.
- g. Drugs not approved by the FDA and drugs not approved by the FDA for a particular use, except off-label drugs used for the treatment of cancer or when *we*, at *our* sole discretion, determine to include the drug on *our formulary* or approve coverage of the drug for the particular use.
- h. Take home drugs when dispensed by a *physician*, physician assistant or advanced practice registered nurse.
- i. Weight loss drugs.
- j. Prescriptions written by a *dentist* unless in connection with dental procedures covered under this *contract*.
- k. Drugs used for *cosmetic* purposes.
- l. Unit dose packaging.
- m. *Prescription drugs* for which the primary purpose is to preserve fertility.

- n. Non-FDA approved route of administration (e.g. drug that is FDA approved for oral use but is being applied topically).
- o. *Prescription drugs* given or administered as part of a drug manufacturer's study.
- p. *Prescription drugs* if purchased by mail order through a program not administered by *our* pharmacy vendor.
- q. *Prescription drugs* for the treatment of sexual dysfunction.
- r. Off-label use of drugs determined to be *investigative*.
- s. Certain *combination drugs* and other drugs if they are listed as not covered on the *formulary*.
- t. *Compounded drugs* that are being used for bio-identical hormone replacement therapy, except as otherwise covered under this section of the *contract*.
- u. Prescribed or non-prescribed vitamins or minerals, including over-the-counter, unless covered as *preventive health care services*.
- v. All medicinal foods, enteral feedings, supplemental feedings, nutritional and electrolyte supplements, and infant formula.
- w. *Specialty drugs* obtained at any pharmacy other than *our* designated specialty pharmacy, except limited distribution *specialty drugs* only available through the manufacturer's select specialty pharmacy and not available through *our* designated specialty pharmacy.
- x. Non-*formulary* drugs, unless an exception is obtained from *us*.
- y. Any portion of a charge for a *prescription drug* which *you* are not required to pay or for which *you* receive reimbursement due to use of a manufacturer's coupon, rebate or other program that alters the amount *you* are legally obligated to pay, and/or waives any *copayment*, *coinsurance* or *deductible* that *you* are required to pay under this *contract*.

Benefit	Participating Provider Benefits, we pay:	Non-Participating Provider Benefits:
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O. Preventive Contraceptive Methods and Counseling for Women

We cover preventive contraceptive methods and counseling services received during the *calendar year* by female *members* as described in the *Preventive Health Care Services Schedule* (“Schedule”) and according to the frequency and time frames stated in the Schedule.

The Schedule, which includes the preventive contraceptive methods and counseling services for women provided by the *Affordable Care Act*, is available on our website at www.aspirushealthplan.com or by calling Customer Service.

This coverage includes the full range of Food and Drug Administration approved contraceptive methods for women with reproductive capacity, including women’s contraceptive drugs, devices, and delivery methods obtained from a retail pharmacy, a mail order pharmacy, or received at a *provider’s* office. For adolescent and adult women, condoms are covered without cost-sharing when prescribed to prevent unintended pregnancies.

Self-administered hormonal contraceptives may be prescribed by a *physician*, physician assistant, advanced practice registered nurse or a licensed pharmacist. We cover up to a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed. “Prescription contraceptive” does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact for purposes of this 12-month supply provision.

Please see section IX.S. “Specified *Non-Participating Provider Services*” for additional *non-participating provider benefits* for voluntary family planning of the conception and bearing of children.

Women’s prescription contraceptives received at a retail pharmacy or mail order pharmacy:

- Generic oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and - Preferred brand and non-preferred brand oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which <u>no</u> generic alternative exists.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Preferred brand and non-preferred brand oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	100% of the amount that would have been payable for the generic alternative. <i>Deductible</i> does not apply. Non-Formulary Not covered, unless a formulary exception is granted. Except as provided in the paragraphs below this schedule, if <i>you</i> request a preferred brand or non-preferred brand contraceptive when a generic alternative exists, <i>you</i> must pay the difference in cost between the applicable preferred brand or non-preferred brand drug and the generic drug.	Not covered.

Women's prescription contraceptives, sterilization procedures, and member education received at a provider's office:		
- Generic injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and - Preferred brand and non-preferred brand injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which <u>no</u> generic alternative exists.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Preferred brand and non-preferred brand injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.
Sterilization procedures, excluding the reversal of sterilization procedures.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Member education and counseling about contraceptive methods.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Same as the <i>participating provider benefit</i>. Please see section IX.S. "Specified Non-Participating Provider Services" for <i>non-participating provider benefits</i> for voluntary family planning of the conception and bearing of children.

Your provider may request an exception for coverage of an FDA-approved, cleared or granted contraceptive product that is not on the *formulary*. If such non-*formulary* contraceptive is a preferred brand or non-preferred brand drug for which a generic is available, once approved, we will pay 100% of the *eligible charges* for the preferred brand or non-preferred brand preventive contraceptive drug when you obtain it from a *participating provider*, and the *deductible* will not apply.

You or your provider may contact Customer Service for a copy of the written guidelines and procedures or for assistance in requesting an exception.

An exception is valid for the duration of the prescription while you are covered under this *contract*, including refills. Your provider may request an exception for subsequent prescriptions following the procedure described in the *Prescription Drug Services* section. The exception does not apply if we remove the drug from the *formulary* for safety reasons. A previously granted exception ends when we remove the drug from the *formulary* for safety reasons.

Notes:

- Hysterectomies are not covered under this section of the *contract*. Please see the "*Hospital Services*" section for applicable benefits.
- Please see the "*Hospital Services*" section for coverage of anesthesia and facility services related to sterilization procedures that are performed during other surgical procedures, such as but not limited to Cesarean section birth, gall bladder removal, and abdominal hernia repair.
- Please see the sections titled "*Hospital Services*," "*Office Visits*" and "*Prescription Drug Services*" for coverage of non-preventive *health care services*.

Exclusions:

- Please see the section entitled "Exclusion List."
- Contraceptives and related *health care services* received from *non-participating providers*, except member education and counseling about contraceptive methods.
- Sterilization procedures performed by *non-participating providers*.
- Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
- Reversal of sterilization procedures.

Benefit	Participating Provider Benefits, we pay:	Non-Participating Provider Benefits, we pay:
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P. Preventive Health Care Services

We cover *preventive health care services* that you receive during the *calendar year* including services designated by the USPSTF as grade A or B, as required under the *Affordable Care Act*. The services required by the *Affordable Care Act* and their frequency and time frames are stated in the *Preventive Health Care Services Schedule* (“Schedule”). The Schedule may be amended from time-to-time, on a prospective basis, and is available on *our* website at www.aspirushealthplan.com or by contacting Customer Service. This *contract* also covers certain *preventive health care services* that are required by state law. They are addressed at the end of this section.

Please see section IX.S. “Specified *Non-Participating Provider Services*” for additional *non-participating provider benefits* for preventive testing for sexually transmitted diseases, including HIV.

The Schedule includes certain routine services such as: • Routine physical examinations. • Routine laboratory tests, pathology and radiology. • Purchase/rental of breast pumps. • Counseling for certain conditions and lactation counseling. • Certain prescribed preventive medications required under the <i>Affordable Care Act</i>. • Pap tests. • Routine screenings for certain other conditions (such as abdominal aortic aneurysm, diabetes, and osteoporosis). • Child health supervision services as required under the <i>Affordable Care Act</i>. Coverage includes pediatric <i>preventive health care services</i>, developmental assessments, and laboratory services appropriate to the age of the child. Note: If any of the services listed above are prenatal or child health supervision services, see the section of this benefit schedule titled “<i>Preventive Health Care Services</i> that are in Addition to Those Required by the <i>Affordable Care Act</i>” for further benefit information.	100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.	Not covered.
• Mammograms and other breast cancer screenings for which coverage is required under the <i>Affordable Care Act</i>.	100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.	Not covered.
• Routine immunizations.	100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.	Not covered.

Colorectal screening tests, including colonoscopy and associated <i>medically necessary health care services</i>, for which coverage is required under the <i>Affordable Care Act</i>	100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.	Not covered.
- Tobacco cessation intervention programs: - Two designated tobacco cessation counseling program attempts per <i>member</i> per <i>calendar year</i>, limited to four counseling sessions per attempt; - Tobacco cessation <i>prescription drugs</i> and prescribed over-the-counter (OTC) medications when used in connection with or separate from a designated tobacco cessation counseling program, are limited to a maximum of 30-calendar days per prescription or refill per <i>member</i> and a total 90-calendar day supply per <i>member</i> per attempt for up to two attempts per <i>member</i> per <i>calendar year</i>. Nicotine replacement products may be prescribed by a <i>physician</i>, physician assistant, advanced practice registered nurse or a licensed pharmacist.	100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.	Not covered.
All recommended, necessary preventive services, depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors, including pre-pregnancy, prenatal, postpartum, and interpregnancy visits.	100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.	Not covered.
Nutritional (or other health) counseling for management of chronic health problems (such as diabetes)	100% of <i>eligible charges</i>. <i>Deductible</i> does not apply.	Not covered.

<i>Preventive Health Care Services that are in Addition to those Required by the Affordable Care Act</i>		
Routine screenings for certain cancers that are not required under the <i>Affordable Care Act</i>, and associated <i>medically necessary health care services</i>.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Colorectal screening tests, including colonoscopy and associated <i>medically necessary health care services</i>, covered under this preventive benefit once every two years.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Breast cancer screenings for which coverage is not required under the <i>Affordable Care Act</i>, covered under this preventive benefit once every <i>calendar year</i>.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Additional diagnostic services or testing if <i>your attending health care professional</i> determines you require additional diagnostic services or testing after a mammogram.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Surveillance tests for ovarian cancer for women, including CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination or other proven ovarian cancer screening tests for women who are <i>at risk for ovarian cancer</i> due to family history or testing positive for BRCA1 or BRCA2 mutations.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Prostate-specific antigen blood tests and digital rectal examinations to screen for prostate cancer for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Routine hearing examination limited to one exam per <i>member</i> per <i>calendar year</i>.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Insulin or other glucose lowering agent on <i>our</i> Preventive Drug List for up to a 30-calendar day supply for one type of insulin or other glucose lowering agent per prescription or refill. Cost-sharing Limits for Insulin. Cost-sharing (i.e. <i>copayment</i>) for insulin is limited to the <i>net price</i> of the insulin.	100% of <i>eligible charges</i> after a <i>copayment</i> of \$25 per 30-calendar day prescription or refill. <i>Deductible</i> does not apply.	Not covered.

Other preventive drugs on <i>our</i> Preventive Drug List, which list includes HIV infection prevention medications, for a 30-day supply. In the case of pre-exposure prophylaxis and post-exposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus, these items do not require prior authorization or step therapy, subject to the exception for therapeutic equivalents set forth Minnesota statutes § 62Q.46(e)	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Routine prenatal care services (as defined below).	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
One routine postnatal care exam that includes a health exam, assessment, education and counseling provided during the period immediately after childbirth.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
Child health supervision services (as defined below).	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.

Prenatal care services means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education and use of routine specialized skills and technology as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists and as required by state law.

Child health supervision services includes pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.

Female *members* may obtain annual preventive health examinations and prenatal care from *specialists* such as obstetricians and gynecologists in the *participating provider* network, without a referral from another *physician*, physician assistant or advanced practice registered nurse or prior approval from *us* or *our* designees.

Notes:

- Non-*preventive health care services* are not covered under this section of the *contract*.
- Non-routine *health care services*, including but not limited to non-routine prenatal services, are not covered under this section of the *contract*.

Exclusions:

- Please see the section entitled “Exclusion List.”
- Any *health care services* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in the *Preventive Health Care Services* section of this *contract*.
- Routine eye examinations, except as covered under the “Vision Care – Pediatric” section of this *contract*.
- Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
- Tobacco cessation intervention programs and related *health care services*, except as covered under this “*Preventive Health Care Services*” section of this *contract*.
- Non-prescribed over-the-counter medications.
- Travel immunizations.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits:</i>
Q. <i>Reconstructive Surgery</i>	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

We cover *medically necessary reconstructive surgery* due to *sickness, accident or congenital anomaly*. *Eligible charges* include *eligible hospital, physician, laboratory, pathology, radiology and facility charges*. Contact Customer Service to determine if a specific procedure is covered.

We also cover *reconstructive surgery following a mastectomy*. *Reconstructive surgery following a mastectomy* includes the following:

1. all stages of reconstruction of the breast on which the mastectomy has been performed if the mastectomy was determined to be *medically necessary* by the *attending health care professional*;
2. surgery and reconstruction of the other breast to produce symmetrical appearance;
3. *prostheses*; and
4. treatment of physical complications at all stages of mastectomy, including lymphedemas.

Services and supplies will be determined in consultation with the *attending health care professional* and patient. Such coverage will be subject to *coinsurance* and other plan provisions.

Exclusions:

- a. Please see the section entitled “Exclusion List.”
- b. *Health care services* to treat conditions that are *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom, except for *emergency services* as required under Minnesota Statutes § 62Q.55 that are the result of complications of an excluded *cosmetic* surgery and for which coverage is provided under the “*Emergency Services*” section of this *contract*.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits:</i>
R. Skilled Care Services	Limited to the first 120 days of <i>confinement</i> for <i>skilled care</i>. Note: A transfer between <i>providers</i> for <i>skilled care</i> does not constitute a new <i>confinement</i> for purposes of the 120-day limitation on <i>confinement</i> for <i>skilled care</i>. <i>You</i> must be admitted to the <i>skilled nursing facility</i> within 24 hours after discharge from a <i>hospital</i> or surgical center or directly from emergency room care, urgent care facility or an <i>attending health care practitioner's</i> office and <i>you</i> must be admitted to the <i>skilled nursing facility</i> for continued treatment of the same <i>sickness</i> or <i>injury</i>.	
	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

We cover the eligible *skilled care* services for post-acute treatment and *rehabilitative care* for *sickness* or *injury*. These services must be certified as *medically necessary* by an *attending health care professional* every seven days. Prior authorization by *us* or *our* designee is required for all confinements for *skilled care*.

Skilled nursing facility services include room and board, daily skilled nursing and related *ancillary services*. Coverage is limited to the first 120 calendar days of *confinement*.

Exclusions:

- a. Please see the section entitled "Exclusion List."
- b. Respite or *custodial care*.
- c. *Skilled nursing facility* care if *health care services* can be provided at a lower level of care (e.g. *home care* or care in an outpatient setting).

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits, we pay:</i>
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S. Specified <i>Non-Participating Provider Services</i>		
• Voluntary family planning of the conception and bearing of children. • The <i>provider</i> visit(s) and test(s) necessary to make a diagnosis of <i>infertility</i>. • Testing for sexually transmitted diseases, AIDS, and other HIV-related conditions. • Treatment of sexually transmitted diseases, except AIDS and other HIV-related conditions.	Covered at the same benefit level as the type of service benefit shown in the schedule for <i>participating provider benefits</i> .	Same as the <i>participating provider benefits</i> .

You are not required to receive the services listed above from a participating provider. An office visit (whether by a participating provider or a non-participating provider) for the services listed will be covered at the participating provider benefit level.

Exclusions:

- a. Please see the section entitled “Exclusion List.”

Benefit	Participating Provider Benefits, we pay:	Non-Participating Provider Benefits:
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T. Vision Care – Pediatric		
Exam (one per <i>calendar year</i>).	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
<i>Medically necessary</i> polycarbonate lenses with scratch coating (one pair per <i>calendar year</i>). - Frames, one pair per <i>calendar year</i>. - Conventional contact lenses to correct visual acuity limitations, in lieu of all other <i>medically necessary</i> eyeglass frames and/or lenses. Coverage is limited to one pair of conventional contact lenses per <i>calendar year</i> or one 12-month series of planned replacement lenses per <i>calendar year</i>. Notwithstanding any other provisions of the <i>contract</i>, contact lenses for children under age 19 are covered whenever <i>medically necessary</i> through the end of the year in which the <i>member</i> reaches age 19.	100% of <i>eligible charges</i> . <i>Deductible</i> does not apply.	Not covered.
<i>Medically necessary</i> low vision services. <i>Medically necessary</i> optional lenses and treatments.	80% of <i>eligible charges</i> after the <i>deductible</i> .	Not covered.

We cover *medically necessary* vision services and materials described above for, or related to, routine eye exams, lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, through the end of the year in which the *member* reaches age 19. Payment is limited to the most cost effective and *medically necessary* alternative. When you purchase lenses, frames, or optical devices that are more expensive than what is considered *medically necessary* by us or our designee, you will be responsible for the difference in purchase and maintenance cost. For information regarding whether any optical device or professional service is *medically necessary*, please call Customer Service.

Frames are limited to one frame per *calendar year*. Your provider will show you which frames are covered by this *contract*.

We also cover *preventive health care services*, including routine screening to detect amblyopia or its risk factors in children ages 3-5. These services will be covered as shown in the *Preventive Health Care Services* section of this *contract* and not this section of the *contract*.

Exclusions:

- Please see the section entitled “Exclusion List.”
- Vision care received from a *non-participating provider*.
- Vision care received after the end of the year in which the *member* reaches age 19.
- Lenses, frames or optical devices that we determine are not *medically necessary*.
- Health care services* or materials not meeting the standards of accepted optometric practices.
- Repairs to frames and lenses.
- Vision therapy.
- Frames that are brand name or mid to high-end fashion frames.
- Replacement of stolen or lost eyewear.
- Non-prescription lenses, including reading glasses without a prescription.
- Two pairs of eyeglasses in lieu of bifocals.

- l. Insurance of contact lenses.
- m. Saline or other solutions for the care of contact lenses.
- n. Prosthetic devices and associated *health care services*.
- o. Sunglasses.
- p. Sport lenses and sport frames.
- q. Special lens designs or coatings not *medically necessary*, including but not limited to special lenses or lens modifications that are not to correct visual acuity problems, tinted lenses, transition lenses, high-index lenses, toric lenses, gas permeable lenses, bifocal contact lenses, progressive or invisible lenses, ultraviolet coating, and photochromic and non-reflective coating.
- r. Replacement of lenses or frames due to *provider* error in prescribing, frame selection or measurement. The *provider* making the error is responsible for bearing the cost of correcting the error.

Benefit	<i>Participating Provider Benefits, we pay:</i>	<i>Non-Participating Provider Benefits:</i>
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U. Abortion and Abortion Related Services		
Abortion and abortion related services, including pre-abortion services and follow-up services “Abortion” means any medical treatment intended to induce the termination of a pregnancy with a purpose other than producing a live birth.	<u>Office Visits:</u> See the “Office Visits” section of this <i>contract</i>. <u>Hospital Services:</u> See the “Hospital Services” section of this <i>contract</i>. <u>Prescription Drugs:</u> See the “Prescription Drug Services” section of this <i>contract</i>.	Not covered.

Exclusions:

- a. Please see the section entitled “Exclusion List.”

X. Exclusion List

In addition to any other exclusions or limitations specified in this *contract* we will not cover charges *incurred* for any of the following:

1. *Health care services* that are not *medically necessary*.
2. *Health care services* that are *investigative*, and associated expenses, except as specified in the “*Routine Patient Costs Associated with Clinical Trials*” section of this *contract*.
3. Charges for *health care services* that are duplicate services.
4. Personal comfort or convenience items.
5. Procedures that are *cosmetic*, or for convenience or comfort reasons, including preoperative procedures and any medical or surgical complications arising therefrom, except for *emergency services* as required under Minnesota Statutes § 62Q.55 that are the result to complications of an excluded *cosmetic* surgery. *Our* Cosmetic Procedures Policy may be obtained by calling Customer Service.
6. *Orthognathic surgery*, except when *medically necessary* for treatment of temporomandibular joint disorder and craniomandibular disorder, treatment of cleft lip or cleft palate, or as otherwise covered under the “*Dental Services*” and “*Hospital Services*” sections of this *contract*.
7. The following procedures and any related *health care services*:
 - a. Injection of filling material (collagen) other than for incontinence;
 - b. Salabrasion;
 - c. Rhytidectomy (face lift);
 - d. Dermabrasion; chemical peel;
 - e. Suction-assisted lipectomy (liposuction);
 - f. Hair removal, other than when *medically necessary* for gender dysphoria;
 - g. Mastopexy;
 - h. Mammoplasty, including augmentation or reduction mammoplasty, except for reconstruction associated with a covered mastectomy or when *medically necessary* for gender dysphoria;
 - i. Correction of inverted nipples;
 - j. Sclerotherapy or other treatment for varicose veins less than 3.5 millimeters in size (e.g. telangiectasias, spider veins, reticular veins);
 - k. Excision or elimination of hanging skin on any part of the body, including panniculectomy, abdominoplasty and brachioplasty. This exclusion does not apply to surgical procedures that are *medically necessary* and recommended by the *physician*, such as but not limited to *medically necessary* blepharoplasty;
 - l. Non-*medically necessary* mastectomy or mastectomy surgery performed for *cosmetic* purposes, except as provided in the “*Reconstructive Surgery*” section of this *contract* or as required under the Women’s Health and Cancer Rights Act (WHCRA) of 1998;
 - m. Botulinum toxin or similar products, unless *you* receive prior authorization;
 - n. Any modification to the body that does not affect its function;
 - o. Labiaplasty, except when *medically necessary* for gender dysphoria;
 - p. Treatment of sialorrhea (drooling or excessive salivation); and
 - q. *Health care services*, including surgical services, for the treatment of excessive sweating (hyperhidrosis).
8. *Oral surgery*, except for fracture of the jaw, trauma of the mouth and jaw and excision of tumors and cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
9. *Health care services* received before *your* coverage with *us* begins or after *your* coverage with *us* ends.
10. *Health care services* not directly related to *your* care.
11. *Health care services* not rendered in the most cost-efficient setting or methodology appropriate for the condition based on medical standards and accepted practice parameters of the community or provided at a frequency other than that accepted by the medical community as medically appropriate. *You* are encouraged to consult with *your provider* regarding the most cost-efficient setting or methodology appropriate for *your sickness* or *injury*.
12. *Health care services* a *provider* ordered or that are rendered by *providers* that are unlicensed or not certified by the appropriate state regulatory agency.
13. Charges that exceed the *non-participating provider reimbursement value* for *health care services* received from *non-participating providers*, including *non-participating provider* pharmacies, except when coverage is required for certain emergency services under Minnesota Statutes § 62Q.55 or certain *unauthorized provider services* under Minnesota Statutes § 62Q.556.

14. *Health care services* prohibited by law or regulation, or illegal under applicable laws.
15. Vision lenses, frames and eyeglasses, except as covered under the “Vision Care – Pediatric” section of this *contract*.
16. Contact lenses and their related fittings received after the end of the year in which *you* turn age 19, unless such lenses are prescribed as *medically necessary* for the treatment of keratoconus.
17. Any *health care services* provided by a relative (i.e., a spouse, parent, brother, sister or child of the *subscriber* or of the *subscriber’s* spouse) or anyone who customarily lives in the *subscriber’s* household.
18. *Health care services* provided by massage therapists, doulas and personal trainers.
19. *Health care services* provided by *providers* who have not completed professional level education and licensure as determined by *us*.
20. *Health care services* for the treatment of sexual dysfunction.
21. Massage therapy, except when billed by a chiropractor, physical therapist or occupational therapist.
22. Preventive medical services and supplies not ordered by a *provider*, including, but not limited to, cholesterol testing, glucose testing and mammograms, unless specifically listed in the schedule of *Preventive Health Care Services* or provided by a *participating provider*.
23. Any charges or loss to which a contributing cause was *your* commission of, or attempt to commit a felony, or to which a contributing cause was due to *your* being engaged in an illegal occupation. This exclusion does not apply to any *sickness* or *injury* that is a result of an act of domestic violence or results from a medical condition such as alcoholism. This exclusion also does not apply to court-ordered mental health services for which coverage is required under Minnesota Statutes § 62Q.535.
24. Financial or legal counseling services.
25. Travel, transportation or living expenses.
26. Photodynamic therapy and laser therapy for the treatment of acne.
27. Homeopathic, holistic or naturopathic medicine, including dietary supplements.
28. Drugs and medical devices that are only approved for compassionate use by the United States Food & Drug Administration, unless the drug is recognized for treatment of cancer in a *standard reference compendia* or in one article in a major peer reviewed medical journal.
29. Costs associated with *clinical trials* that are not *routine patient costs*.
30. Non-emergency *health care services* performed directly in connection with the performance of non-covered *health care services*.
31. *Health care services* and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise *medically necessary*, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for driving under the influence/driving while intoxicated, competency evaluations, and adoption studies.
32. *Health care services* provided in connection with any *sickness* or *injury* arising out of, or sustained in the course of any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers’ compensation insurance. This exclusion applies regardless of whether benefits under workers’ compensation laws or any similar laws have been claimed, paid, waived or compromised.
33. *Health care services* furnished by the U.S. Veterans Administration, unless federal law designates the *contract* as the primary payor and the U.S. Veterans Administration as the secondary payor.
34. *Health care services* furnished by any federal or state agency or a local political subdivision when *you* are not liable for the costs in absence of insurance, unless such coverage under the *contract* is required by law.
35. Halfway houses (except *covered services* provided to *you* at a halfway house), extended care facilities or comparable facilities, foster care, adult foster care, and family childcare.
36. Professional services associated with substance use disorder intervention. A substance use disorder intervention is a gathering of family and/or friends to encourage *you* to seek substance use disorder treatment.
37. Sterilization reversals.
38. Nutritional and food supplements, except for folic acid as covered under the *Preventive Health Care Services* Schedule.
39. *Cochlear implants*, except for *members* with hearing loss that is not correctable by other covered procedures.

40. Health care professional services for maternity labor and delivery in the home.
41. Health club memberships.
42. Acupuncture.
43. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT and Lovaas.
44. Recreational, *educational*, or self-help therapy or items that are primarily *educational* in nature or for vocation, comfort, convenience or recreation. Recreation therapy is therapy provided solely for the purpose of recreation, including, but not limited to: a) physical therapy or occupational therapy to improve athletic ability, and b) braces or guards to prevent sports injuries. This exclusion does not include diabetic outpatient self-management training and education in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association as covered under the "Office Visits" section of this *contract*.
45. Sexual dysfunction *prescription drugs*, unless otherwise covered in this *contract* or approved for other use by an authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case reports.
46. Any weight loss programs and related services and/or drugs, except as otherwise covered as *preventive health care services*.
47. Private duty nursing, unless *medically necessary* and as covered under the *Hospital Services* section of this *contract*. This exclusion does not apply if *you* are also covered under Medical Assistance and coverage for *home care* nursing services is required by Minnesota Statutes § 62Q.545.
48. Charges for *health care services*: (a) for which a charge would not have been made in the absence of health insurance; (b) for which *you* are not legally obligated to pay; and/or (c) from *providers* who waive any *copayment*, *coinsurance*, or *deductible* that *you* are required to pay under this *contract*, except as required under state or federal law.
49. Non-emergency *services* received outside the United States.
50. *Health care services* related to surrogate pregnancy for a person who is not a *member* under this *contract*.
51. *Health care services* for gender reassignment, except when *medically necessary*.
52. Photographs, except for the condition of multiple dysplastic syndrome.
53. Coverage for costs associated with the translation of medical records and claims to English.
54. Repair of pierced body parts and surgical repair of bald spots or loss of hair.
55. Services for or related to adoption and childbirth classes.
56. Services or *confinements* ordered by a court or law enforcement officer that are not *medically necessary*. Services that are not considered *medically necessary* include, but are not limited to, the following: custody evaluations, parenting assessment and /or competency, education classes for Driving Under the Influence (DUI) / Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, and domestic violence programs , unless required by statute. This exclusion does not apply to substance use disorder services.
57. Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer the therapy.
58. Services that do not involve direct patient contact such as delivery charges and recordkeeping.
59. Non-FDA approved use of medical marijuana, cannabis or tetrahydrocannabinol (THC).
60. Costs, charges, fees and other losses for non-*health care services*.
61. Services provided during a *telehealth* visit for the sole purpose of: scheduling appointments; filling or renewing existing prescriptions; reporting normal medical test results; providing *educational* materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; or services that would similarly not be charged for in an onsite medical office visit; or telephone conversations, e-mails, or facsimile transmissions between licensed health care *providers*; or e-mails, or facsimile transmissions between a licensed health care *provider* and a patient.
62. Prolotherapy.
63. Platelet-rich plasma.
64. Coma stimulation/recovery programs.

65. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
66. Salivary Hormone Testing.
67. Claims for benefits to the extent such claims have been paid under workers' compensation, employer liability or any similar law, auto insurance, or any other coverage or plan. *We* will not make duplicate payment on claims that have been paid previously by such other payer.
68. Reversal of voluntary sterilization.

The following exclusions are repeated from the “Description of Benefits” section”:

***For ease of reference, some exclusions may contain headings for categories of *health care services*.**

69. Ambulance Services:
 - a. See all exclusions.*
 - b. Non-emergency ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
70. Chiropractic Services:
 - a. See all exclusions.*
 - b. *Maintenance care*.
 - c. Blood, urine or hair analysis.
 - d. Manipulation under anesthesia.
71. Dental Services:
 - a. See all exclusions.*
 - b. Dental services covered under *your* dental plan.
 - c. Preventive dental procedures.
 - d. *Health care services* or dental services for and related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts.
 - e. Orthodontia and all associated expenses, except for the treatment of cleft lip and cleft palate
 - f. *Health care services* or dental services for or related to *oral surgery* and anesthesia for the removal of impacted teeth, removal of a tooth root without the removal of the whole tooth and root canal therapy.
 - g. *Health care services* or dental services for cracked or broken teeth that result from biting, chewing, disease or decay.
 - h. Dental implants, except due to *injury*.
 - i. Prescriptions written by a *dentist* unless in connection with dental procedures covered by *us*.
 - j. *Health care services* or dental services related to periodontal disease.
 - k. Occlusal adjustment or occlusal equilibration.
 - l. Treatment of bruxism.
 - m. Surgical extraction of impacted wisdom teeth, except as above for accidental *injury* to sound, natural teeth or when required for treatment of an underlying medical condition.
72. Durable Medical Equipment (“DME”) Services, *Prosthetics*, and *Orthotics*:
 - a. See all exclusions.*
 - b. Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage. This exclusion does not apply to certain medical supplies such as catheters and diabetic supplies. Please contact Customer Service for further assistance in determining which medical supplies are eligible for coverage under this “Durable Medical Equipment (DME) Services, *Prosthetics*, and *Orthotics*” section of this *contract*. *You* may also access the list of durable medical equipment, *orthoses/orthotics, prosthetics* and supplies (DMEPOS List) at <https://p1.aspirushealthplan.com/getting-care/medical-policy/dme/> to determine which items are eligible for coverage under this *contract*.
 - c. Repair, adjustment, or replacement of parts for durable medical equipment and *prosthetics*, except when made necessary by normal wear or use.
 - d. Routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of a one-month rental billed every six months.
 - e. Replacement of equipment unless *we* determine it is *medically necessary*.
 - f. Replacement of over-the-counter batteries.
 - g. Duplicate or similar items.
 - h. Devices and computers to assist in communication and speech.
 - i. Durable medical equipment that *we* determine to be for *your* comfort, personal hygiene, or convenience including, but not limited to, personal fitness equipment and self-help devices not medical in nature.
 - j. Continuous passive motion (CPM) devices and mechanical stretching devices.

- k. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs and cryotherapy; and home automated external defibrillator (AED).
- l. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
- m. Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
- n. Over-the-counter *orthotics* and appliances.
- o. Orthopedic shoes except when:
 - i. Permanently attached to a covered *orthotic* or *prosthetic* brace; or
 - ii. *Medically necessary* as therapeutic footwear for diabetics; or
 - iii. Required for a significant foot deformity where inserts alone are not sufficient.
- p. Charges for sales tax, mailing and delivery.
- q. Durable medical equipment that is necessary for the operation of other durable medical equipment which is determined to not be eligible for coverage.
- r. Durable medical equipment, *orthotics* and *prosthetics* necessary for activities beyond *activities of daily living*.
- s. Durable medical equipment, *orthotics* and *prosthetics* that we determine to have special features that are not *medically necessary*.
- t. Wigs, toupees, hairpieces, and cranial prosthesis for conditions other than hair loss suffered as a result of illness such as alopecia areata or treatment for cancer.
- u. Hair implants, hair transplants, hair weaving, or hair loss prevention treatments.
- v. Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.
- w. Blood pressure cuffs and monitors.
- x. Enuresis alarms.
- y. Trusses.
- z. Ultrasonic nebulizers.
- aa. Oral appliances for snoring.

73. *Emergency Services:*

- a. See all exclusions.*
- b. Non-emergency services received in an emergency room.
- c. Services received in an emergency room that do not meet the definition of *emergency medical condition* as described in Section XX. Definitions.

74. *Hearing Aids, Implantable Hearing Devices and Related Services:*

- a. See all exclusions.*
- b. Hearing protection equipment.
- c. *Hearing aid* batteries and cords.
- d. Over-the-counter *hearing aids*.

75. *Home Care Services:*

- a. See all exclusions.*
- b. Companion and *home care* services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
- c. Services provided as a substitute for a primary caregiver in the home.
- d. Services that can be performed by a non-medical person or self-administered.
- e. Services provided in *your* home for convenience.
- f. Services provided in *your* home due to lack of transportation.
- g. *Custodial care*.
- h. *Home care* services at any site other than *your* home. This exclusion does not apply to coverage for up to 120 hours of services provided by a *home care* nurse or personal care assistant to a ventilator-dependent person during the time the ventilator-dependent person is in a *hospital*.
- i. Recreational therapy.
- j. Domiciliary Care, such as meals-on-wheels, health visiting, and home help.

76. *Hospice Care:*

- a. See all exclusions.*
- b. *Health care services* and other services provided by *your* family or a person who shares *your* legal residence.
- c. Respite or rest care, except as specifically described in this section.

77. *Hospital Services:*

- a. See all exclusions.*
- b. Travel, transportation, other than ambulance transportation, or living expenses.
- c. Non-emergency ambulance service from *hospital to hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
- d. *Health care services* to treat conditions that are *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom, except for *emergency services* as required under Minnesota Statutes § 62Q.55 that are the result to complications of an excluded *cosmetic* surgery and for which coverage is provided under the “*Emergency Services*” section of this *contract*.
- e. Orthoptics and surgery for refractive conditions correctable by contacts or glasses (i.e., Lasik surgery).
- f. *Health care services* for gender reassignment, except when *medically necessary*.
- g. Genetic testing and associated *health care services*, unless *medically necessary* or as otherwise covered under the “*Hospital Services*” and “*Office Visits*” sections of this *contract*.
- h. Hypnosis.
- i. Chelation therapy, except when *medically necessary* for the treatment of heavy metal poisoning.
- j. Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
- k. Autopsies.
- l. *Bariatric surgeries*, including preoperative procedures, initial procedures, surgical revisions and subsequent procedures.
- m. Services or items for personal convenience, such as television rental.
- n. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
- o. Nutritional counseling, except as covered under the “*Hospital Services*,” “*Office Visits*,” and “*Preventive Health Care Services*” sections of this *contract*.
- p. Marital counseling, relationship counseling, family counseling or other similar counseling or training services, except as covered under the “*Hospital Services*” and “*Office Visits*” sections of this *contract*.
- q. Services to hold or confine a *member* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
- r. Counseling, studies, *confinements*, *health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by us or our designee, except as covered under this “*Hospital Services*” section of the *contract*.
- s. Nutritional and food supplements, except for folic acid as covered under the *Preventive Health Care Services* Schedule and amino acid based elemental formulas as covered under the “*Durable Medical Equipment (“DME”) Services, Prosthetics, and Orthotics*” Section of this *contract*.
- t. Cardiac rehabilitation beyond Phase II.
- u. *Biofeedback* received in a hospital setting.

78. *Infertility Services:*

- a. See all exclusions.*
- b. Reversal of voluntary sterilization.
- c. Adoption costs.
- d. *Health care services* associated with expenses for *infertility*, including assisted reproductive technology, except for those services related to a covered medical condition.
- e. Direct attempts to achieve pregnancy or increase chances of pregnancy by any means.
- f. Any laparoscopic procedure during which an ovum is manipulated for the purpose of *fertility treatment* even if the laparoscopic procedure includes other purposes.
- g. Gamete intrafallopian transfer (GIFT) procedures.
- h. Zygote intrafallopian transfer (ZIFT) procedures.
- i. Intracytoplasmic sperm injection (ICSI).
- j. In-vitro fertilization.
- k. *Health care services* related to surrogate pregnancy for a person who is not a *member* under this *contract*.
- l. Artificially assisted technology, such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
- m. Sperm, ova or embryo acquisition, retrieval or storage.
- n. *Prescription drugs* for which the primary purpose is to preserve fertility.

79. *Office Visits:*

- a. See all exclusions.*
- b. Health education, except when:
 - i. Provided during an office visit for non-preventive *health care services*; or
 - ii. It is counseling that is treated as a *preventive health care service*.
- c. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.

- d. Nutritional counseling, except as covered under the “Hospital Services,” “Office Visits,” and “*Preventive Health Care Services*” sections of this *contract*.
 - e. Marital counseling, relationship counseling, family counseling, or other similar counseling or training services, except as covered under the “*Hospital Services*” and “*Office Visits*” sections of this *contract*.
 - f. Professional sign language and foreign language interpreter services in a *provider’s* office.
 - g. Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or treated as a *preventive health care service*.
 - h. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by *us* or *our* designee.
 - i. Genetic testing and associated *health care services*, unless *medically necessary* or as otherwise covered under the “*Hospital Services*” and “*Office Visits*” sections of this *contract*.
 - j. Hypnosis.
 - k. Chelation therapy, except when *medically necessary* for the treatment of heavy metal poisoning.
 - l. Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
 - m. Vision therapy/orthoptics.
 - n. Counseling, studies, *confinements*, *health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by *us* or *our* designee, except as covered under this “*Office Visits*” section of the *contract*.
 - o. Nutritional and food supplements, except for folic acid as covered under the *Preventive Health Care Services* schedule and amino acid-based elemental formulas and enteral feedings as covered under the “*Durable Medical Equipment (“DME”) Services, Prosthetics, and Orthotics*” section of this *contract*.
 - p. *Conversion therapy*.
80. Organ and Bone Marrow Transplant Services:
- a. See all exclusions.*
 - b. *Transplant services* received from a *provider* that is not a *designated transplant network provider*.
 - c. *Health care services* related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are *investigative* for *your* diagnosis or condition.
 - d. *Health care services*, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by *us* or *our* designee.
 - e. *Health care services*, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.
 - f. Non-emergency ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
 - g. Treatment of medical complications to a donor after procurement of a transplanted organ.
 - h. Computer search for donors.
 - i. Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
 - j. Travel expenses related to a covered transplant.
 - k. *Health care services* for or in connection with fetal tissue transplantation, except for non-*investigative* stem cell transplants.
 - l. Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of US Food and Drug Administration (FDA) approved ventricular assist devices and transplants of artificial or mechanical devices as a bridge to a transplant or destination therapy.
81. Physical Therapy, Occupational Therapy and Speech Therapy:
- a. See all exclusions.*
 - b. *Custodial care* or *maintenance care*.
 - c. Therapy provided in *your* home for convenience.
 - d. Therapy for conditions that are self-correcting.
 - e. Voice training and voice therapy absent a medical condition.
 - f. *Investigative* therapies.
 - g. Group therapy for physical therapy, occupational therapy and speech therapy.
 - h. *Health care services* for homeopathy and immunoaugmentive therapy.
82. Prescription Drug Services:
- a. See all exclusions.*
 - b. *Prescription drugs* obtained from a pharmacy that is a *non-participating provider*.
 - c. Replacement of a *prescription drug* due to loss, damage, or theft.
 - d. Drugs available over-the-counter (OTC), except prescribed OTC drugs that are required to be covered as *preventive health care services* under the *Affordable Care Act* as covered under the “*Preventive Contraceptive Methods and Counseling for Women*” or “*Preventive Health Care Services*” sections of this *contract*.

- e. *Prescription drugs* equivalent to or similar to OTC drugs, except as provided in the drug *formulary*.
 - f. OTC home testing products, except diabetic supplies, glucose monitors and blood and urine test strips for diabetes, or as otherwise covered under state or federal law.
 - g. Drugs not approved by the FDA and drugs not approved by the FDA for a particular use, except off-label drugs used for the treatment of cancer or when *we*, at *our* sole discretion, determine to include the drug on *our formulary* or approve coverage of the drug for the particular use.
 - h. Take home drugs when dispensed by a *physician*, physician assistant or advanced practice registered nurse.
 - i. Weight loss drugs.
 - j. Prescriptions written by a *dentist* unless in connection with dental procedures covered under this *contract*.
 - k. Drugs used for *cosmetic* purposes.
 - l. Unit dose packaging.
 - m. *Prescription drugs* for which the primary purpose is to preserve fertility.
 - n. Non-FDA approved route of administration (e.g. drug that is FDA approved for oral use but is being applied topically).
 - o. *Prescription drugs* given or administered as part of a drug manufacturer's study.
 - p. *Prescription drugs* if purchased by mail order through a program not administered by *our* pharmacy vendor.
 - q. *Prescription drugs* for the treatment of sexual dysfunction.
 - r. Off-label use of drugs determined to be *investigative*.
 - s. Certain *combination drugs* and other drugs if they are listed as not covered on the *formulary*.
 - t. *Compounded drugs* that are being used for bio-identical hormone replacement therapy, except as otherwise covered under this section of the *contract*.
 - u. Prescribed or non-prescribed vitamins or minerals, including over-the-counter, unless covered as *preventive health care services*.
 - v. All medicinal foods, enteral feedings, supplemental feedings, nutritional and electrolyte supplements, and infant formula.
 - w. *Specialty drugs* obtained at any pharmacy other than *our* designated specialty pharmacy, except limited distribution *specialty drugs* only available through the manufacturer's select specialty pharmacy and not available through *our* designated specialty pharmacy.
 - x. Non-*formulary* drugs, unless an exception is obtained from *us*.
 - y. Any portion of a charge for a *prescription drug* which *you* are not required to pay or for which *you* receive reimbursement due to use of a manufacturer's coupon, rebate or other program that alters the amount *you* are legally obligated to pay, and/or waives any *copayment*, *coinsurance* or *deductible* that *you* are required to pay under this *contract*.
83. Preventive Contraceptive Methods and Counseling for Women:
- a. See all exclusions.*
 - b. Contraceptives and related *health care services* received from *non-participating providers*, except *member* education and counseling about contraceptive methods.
 - c. Sterilization procedures performed by *non-participating providers*.
 - d. Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
 - e. Reversal of sterilization procedures.
84. *Preventive Health Care Services*:
- a. See all exclusions.*
 - b. Any *health care services* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in the *Preventive Health Care Services* section of this *contract*.
 - c. Routine eye examinations, except as covered under the "Vision Care – Pediatric" section of this *contract*.
 - d. Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
 - e. Tobacco cessation intervention programs and related *health care services*, except as covered under this "*Preventive Health Care Services*" section of this *contract*.
 - f. Non-prescribed over-the-counter medications.
 - g. Travel immunizations.
85. *Reconstructive Surgery*:
- a. See all exclusions.*
 - b. *Health care services* to treat conditions that are *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom, except for *emergency services* as required under Minnesota Statutes § 62Q.55 that are the result of complications of an excluded *cosmetic* surgery and for which coverage is provided under the "*Emergency Services*" section of this *contract*.
86. *Skilled Care Services*:
- a. See all exclusions.*
 - b. Respite or *custodial care*.
 - c. *Skilled nursing facility* care if *health care services* can be provided at a lower level of care (e.g. *home care* or care in an outpatient setting).

87. Specified *Non-Participating Provider Services*
- a. See all exclusions.*
88. Vision Care – Pediatric:
- a. See all exclusions.*
 - b. Vision care received from a *non-participating provider*.
 - c. Vision care received after the end of the year in which the *member* reaches age 19.
 - d. Lenses, frames or optical devices that *we* determine are not *medically necessary*.
 - e. *Health care services* or materials not meeting the standards of accepted optometric practices.
 - f. Repairs to frames and lenses.
 - g. Vision therapy.
 - h. Frames that are brand name or mid to high-end fashion frames.
 - i. Replacement of stolen or lost eyewear.
 - j. Non-prescription lenses, including reading glasses without a prescription.
 - k. Two pairs of eyeglasses in lieu of bifocals.
 - l. Insurance of contact lenses.
 - m. Saline or other solutions for the care of contact lenses.
 - n. Prosthetic devices and associated *health care services*.
 - o. Sunglasses.
 - p. Sport lenses and sport frames.
 - q. Special lens designs or coatings not *medically necessary*, including but not limited to special lenses or lens modifications that are not to correct visual acuity problems, tinted lenses, transition lenses, high-index lenses, toric lenses, gas permeable lenses, bifocal contact lenses, progressive or invisible lenses, ultraviolet coating, and photochromic and non-reflective coating.
 - r. Replacement of lenses or frames due to *provider* error in prescribing, frame selection or measurement. The *provider* making the error is responsible for bearing the cost of correcting the error.
89. Abortion and Abortion Related Services:
- a. See all exclusions.*

XI. Ending *Your* Coverage

Coverage of the *subscriber* and/or the *subscriber's dependents* will terminate on the earliest of the following dates, except that coverage may be continued in some instances as specified in the "Portability of Coverage" section:

Your coverage under this *contract* will end on the earliest of the following dates:

1. The date *we* discontinue or do not renew this *contract* as provided herein.
1. The end of the month in which *we* receive *your* written request to cancel coverage, unless a later date is requested.
2. The end of the month in which *you* ceased to be eligible for coverage under this *contract*.
3. The end of the month in which the *subscriber's* covered spouse or covered *dependent* is no longer eligible as a covered spouse or covered *dependent*.
4. For a *subscriber's* spouse who is a *covered person*, the end of the month in which the *subscriber's* spouse is no longer married to the *subscriber* due to divorce or annulment.
5. For a grandchild of the *subscriber* or the *subscriber's* covered lawful spouse, the end of the month following the earlier of:
(a) the date the grandchild no longer resides with the *subscriber*, (b) the date the grandchild is no longer financially dependent upon the *subscriber*, or (c) the date the grandchild reaches the age of 25, unless the grandchild is otherwise eligible for coverage under *your* plan.
6. In accordance with the terms of the applicable grace period, if *premium* has not been paid.
7. The date *you* (or someone acting on *your* behalf) performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of this *contract*, according to the notice *we* provide when *we* rescind or terminate this *contract*.
8. The end of the month following the date *you* enter active military duty of more than 31 calendar days. Upon completion of active military duty, *your* coverage will be reinstated, provided *you* notify *us* within 90 calendar days after the end of *your* active duty.
9. The end of the month or such later date, as determined by *us*, after the *subscriber* moves outside the state of Minnesota.
10. The date on which *you* contact MNsure *and* request termination of this Policy or another prospective date that *you* choose;
11. The date *you* no longer qualify for coverage in a *qualified health plan* through MNsure.
12. The day before the effective date of coverage of a new *qualified health plan* if *you* enroll in another *qualified health plan* during the annual open enrollment period or during a special enrollment period.
13. The date this *contract* ceases to be a *qualified health plan* and is decertified by MNsure.
14. *You* will be given 30 days' notice of any cancellation or nonrenewal of this *contract*, except that:
 - a. if *you* are enrolled in an individual health plan which is discontinued in Minnesota *we* will provide written notice to *you* no later than 90 days before the date that the plan is discontinued; or
 - b. if *your* coverage is terminated and you become entitled to replacement coverage under Minnesota statutes section 62D.121, subdivision 1, then *we* will provide notice of termination 90 days before the date the termination takes effect.

XII. Portability of Coverage

A. Continuation of Benefits to Survivors

Upon the death of the *subscriber*, *dependent* survivors are entitled to continue coverage under this policy until the earlier of the following dates:

1. the date the surviving spouse becomes covered under another group *health plan*; or
2. the date coverage would have terminated under the *contract* had the *subscriber* lived.

B. Continuation of Benefits to *Dependents of Subscribers* enrolled in Medicare

Upon the *subscriber* becoming enrolled for benefits under Title XVIII of the Social Security Act (Medicare), the spouse and *dependent* children may elect to continue coverage until the earlier of the following dates:

1. the date coverage would otherwise terminate under the policy;
2. 36 months after continuation by the spouse or *dependent* was elected; or
3. the spouse or *dependent* children become covered under another group *health plan*.

C. Continuation of Benefits to *Dependent Children who Cease to be Dependents*

Upon a *dependent* child ceasing to be a *dependent* under this *contract*, the *dependent* may elect to continue coverage until the earlier of the following dates:

1. the date coverage would otherwise terminate under the policy;
2. 36 months after continuation by the spouse or *dependent* was elected; or
3. the spouse or *dependent* children become covered under another group *health plan*.

D. Continuation of Benefits to *Dependents* upon a Break in the Marital Relationship.

Upon a break in the marital relationship between the *subscriber* and *dependent* spouse the dependent spouse and any *dependent* children may elect to continue coverage until the earlier of the following dates:

1. the date the insured's former spouse becomes covered under any other group *health plan*; or
2. the date coverage would otherwise terminate under the policy.

E. General Provisions

1. In order to continue coverage under this *contract*, the *dependent* or spouse electing continuation must pay the entire cost of the monthly *premiums* required under this *contract*, which shall not exceed 102% of the cost to the *contract* for other similarly situated spouses and *dependents*.
2. When applicable, we will allow the covered *dependents* of the *subscriber* to remain covered under this *contract* as long as a covered spouse becomes the *subscriber* to the *contract* or, if there is no covered spouse, each dependent child may transfer as a *subscriber* to another substantially similar *contract* offered by us. *Dependents* under age 18 may become *subscribers* only if they receive parental or guardian consent. We will permit the transfer (if election is made within 31 calendar days of the date of loss of coverage) without any limitation or other restriction of any type other than those which applied to the *subscriber* under the prior contract.
3. If you transfer to a substantially similar contract offered by us, any amounts that you already paid under this *contract* for covered services that are subject to *coinsurance*, *deductibles* and *out of pocket limits*, or that you received that are subject to benefit limits or visit maximums, and any covered services that you received that are subject to benefit limits or visit maximums under this *contract*, will continue to count toward any applicable *deductibles*, *out of pocket limits*, benefit limits and/or visit maximums.

XIII. Subrogation and Reimbursement

Our Subrogation Rights

For the purposes of this section, “subrogation” means *our* right to allocate risk in accordance with Minn. Stat. § 62A.095 and § 62A.096 so that *your* medical claims are ultimately paid by the party that should rightfully bear the burden of the loss.

1. *We* are subrogated to any and all claims and causes of action that might arise against any person, corporation, and/or other entity and any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision, liability insurance policies, homeowners liability insurance coverage, medical malpractice insurance coverage, patient compensation fund, and any applicable umbrella insurance coverage or other insurance or funds; and
2. *Our* subrogation interest is the reasonable cash value of any benefits received by *you*. *Our* right to subrogate will not apply unless *you* have been made whole for *your* losses related to *your* sickness or injury from another source of compensation for *your* sickness or injury; and
3. *Our* right to recover *our* subrogation interest is subject to a pro rata subtraction for actual monies paid for costs and reasonable attorney fees *you* pay in obtaining *your* recovery unless *we* are separately represented by an attorney; and
4. If *we* are separately represented by an attorney, the attorney representing *us* and the attorney representing the covered person may enter into an agreement regarding allocation of costs and reasonable attorney fees. If *we* and the covered person cannot reach agreement on allocation, *we* and the covered person shall submit the matter to binding arbitration to the extent permitted under applicable state law and in compliance with such law; and
5. Nothing in this section shall limit *our* right to recovery from another source which might otherwise exist at law.

Notice Requirement

You must provide timely written notice to *us* of the pending claim, if *you* make a claim against a third party for damages that include repayment for medical and medically related expenses *incurred* for *your* benefit. Notwithstanding any other law to the contrary, the statute of limitations applicable to *our* rights for reimbursement or subrogation does not commence to run until the notice has been given.

XIV. Coordination of Benefits

As a *member*, you agree to permit *us* to coordinate *our* obligations under this *contract* with payments under any other health benefit plans as specified below, which cover *you* as a *subscriber* or *dependent*. You also agree to provide any information or submit any claims to other health benefit plans necessary for this purpose. You agree to authorize *our* billing to other *health plans*, for purposes of coordination of benefits.

Unless applicable law prevents disclosure of the information without the consent of *you* or *your* representative, *you* must provide any facts needed to pay the claim. If the information cannot be disclosed without consent, *we* will not pay benefits until the information is given.

Application. This Coordination of Benefits provision applies when *you* have health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan might cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Definitions. These definitions only apply to the Coordination of Benefits provision.

Allowable Expenses. Means *health care services* or expenses, including *copayments*, *deductibles* and *coinsurance* that are covered at least in part by any of the plans covering *you*. When a plan provides benefits in the form of services (for example a staff model HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.

Claim Determination Period. Means a *calendar year*. However, it does not include any part of a year during which *you* have no coverage under this *contract*, or before the date this Coordination of Benefit provision or a similar provision takes effect.

Closed Panel Plan. Means a plan that provides health benefits to persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the plan and that limits or excludes benefits or services provided by other *providers*, except in cases of emergency or referral by a panel member.

Custodial Parent. Means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

Plan. Means any of the following that provides benefits or services for medical or dental care or treatment.

1. Group, blanket, franchise, closed panel or other forms of group or group type coverage (insured or uninsured).
2. Hospital indemnity benefits in excess of \$200 per day.
3. Medical care components of group long-term care policies, such as skilled nursing care.
4. A labor-management trustees plan or a union welfare plan.
5. An employer or multi-employer plan or employee benefit plan.
6. Medicare or other governmental benefits, as permitted by law.
7. Insurance required or provided by statute.
8. Medical benefits under group or individual automobile policies.
9. Individual or family insurance for *hospital* or medical treatment or expenses.
10. Closed panel or other individual coverage for *hospital* or medical treatment or expenses.

Plan does not include any:

1. Amounts of hospital indemnity insurance of \$200 or less per day.
2. Benefits for non-medical components of group long-term care policies.
3. School accident type coverages.
4. Medicare supplement policies.
5. Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage listed above is a separate plan. If a plan has two parts and Coordination of Benefits rules apply to one of the two, each of the parts is treated as a separate plan. The benefits provided by a plan include those that would have been provided if a claim had been duly made.

Primary Plan/Secondary Plan. Means the order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan," when compared to the other plan covering *you*.

When this *contract* is the primary plan, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this *contract* is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

Order of Benefit Determination Rules. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

This plan determines its order of benefits by using the first of the following that applies:

1. **Workers' compensation.** *You* should submit claims for expenses incurred as a result of a work-related *sickness* or *injury* to the employer, or the employer's workers compensation carrier, for coverage under any worker's compensation or similar law, as well as submitting them to Aspirus Health Plan, Inc.
2. **Automobile insurance.** *You* should submit claims for expenses incurred as a result of an auto accident or *injury* to the responsible automobile insurance carrier, as well as submitting them to Aspirus Health Plan, Inc.
3. **Nondependent/Dependent:** The plan that covers the person other than as a dependent, for example as an employee, *subscriber*, or retiree, is the primary plan; and the plan that covers the person as a dependent is the secondary plan.

Exception: If the person is a Medicare beneficiary and federal law makes Medicare:

- a. secondary to the plan covering the person as a *dependent*; and
 - b. primary to the plan covering the person as a nondependent (e.g., a retired employee);
- then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary.

4. **Child Covered Under More Than One Plan:** The order of benefits when a child is covered by more than one plan is:
 - a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - i. The parents are married;
 - ii. The parents are not separated (whether or not they ever have been married); or
 - iii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.
 - b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
 - c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - i. The plan of the custodial parent;
 - ii. The plan of the spouse of the custodial parent;
 - iii. The plan of the non-custodial parent; and then
 - iv. The plan of the spouse of the non-custodial parent.
 - d. For a child covered under more than one plan by persons who are not the parents of such child, the order of benefits shall be determined under paragraph 2.a. of this section as if those persons were parents of such child.
 - e. For a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the rule in paragraph 5 of this section applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in paragraph 2.a of this section to the dependent child's parent(s) and the dependent child's spouse.
5. **Active/Inactive Employee:** The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits. For example, coverage provided to a person as a retired worker and as a dependent of an actively working spouse will be determined under the rule in paragraph 1.
6. **Continuation Coverage:** If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:
 - a. The plan covering the person as an employee, *member*, *subscriber*, or retiree (or as a *dependent* of an employee, *member*, *subscriber*, or retiree) is the primary plan; and
 - b. The continuation coverage is the secondary plan.

If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits.

7. **Longer/Shorter Length of Coverage.** The plan that covered *you* as an employee, *member*, *subscriber* or retiree longer is primary.

Note: Under this *contract*, we will not pay more than we would pay as the primary plan.

The Effect of the Benefits of this Plan: When this plan is secondary, it may reduce its benefits at the time of processing, so that the total benefits paid or provided by all plans for each claim are not more than 100% of total allowable expenses for such claim. The reduction in this plan's benefits is equal to the difference between:

1. The benefit payments that this plan would have paid had it been the primary plan; and
2. The benefit payments that this plan actually paid or provided.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion to any applicable limit, such as the *deductible* of this plan.

Right to Receive and Release Information. Certain facts about health care coverage and services are needed to apply Coordination of Benefit rules and to determine benefits payable under this plan and other plans. *We* may get the facts from or give them to any other organization or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. *We* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give *us* any facts *we* need to apply those rules and determine benefits payable. Release of information will comply with state and federal laws.

Facility of Payment. A payment made under another plan may have included an amount that should have been paid under this plan. If it does, *we* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this plan. *We* will not pay that amount again. The term "payment made" includes providing benefits in the form of services. In this case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by *us* is more than it should have paid, *we* may recover the excess from one or more of the following:

1. The persons *we* have paid or for whom *we* have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided to *you*.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordinating with Medicare: This section describes the method of payment if Medicare pays as the primary plan.

If a *provider* has accepted assignment of Medicare, *we* determine allowable expenses based upon the amount allowed by Medicare. *Our* allowable expenses are the lesser of (1) the *fee schedule* amount; (2) the *non-participating provider reimbursement value*, as applicable; or (3) the Medicare allowable amount. *We* pay the difference between what Medicare pays and *our* allowable expenses.

When Medicare would be the primary plan, but *you* are eligible for Medicare and have not enrolled in Medicare, then *we* will pay as the primary plan.

Renal Failure. If *you* begin to have services related to renal failure, *we* request that *you* sign up for Medicare.

XV. How to Submit a Claim if *You* Receive a Bill for *Covered Services* from a *Provider*

Claim Forms. If *you* submit a notice of claim to *us* without adequate written proof of loss, *we* will furnish *you* a claim form for filing *your* proof of loss. If *you* are not furnished a claim form within 15 calendar days after *you* provided notice of a claim to *us*, *you* should submit written proof which documents the date of service, the type of service, a specific medical diagnosis and treatment, service or procedure code, *provider* name and itemized charges for which the claim is made.

Timely Payment of Claims. *Post-service claims* for benefits will be paid promptly upon receipt of an itemized bill and written proof of loss. Benefits that are payable periodically during a period of continuing loss will be paid monthly. All or any portion of any benefits provided by *us* may be paid directly to the *provider* rendering the services. Payment will be made according to *our* coverage guidelines.

Payment of Claims. All or any portion of any benefits provided to *you* or on *your* behalf for *hospital*, nursing, medical or surgical services may, at *our* option, be paid directly to the *hospital* or *provider* providing such services.

At *our* option, all payments for claims may be made directly to the *provider* of medical services, the custodial parent or Department of Human Services rather than to the *subscriber*, for claims *incurred* by a child who is covered as a *dependent* of a *subscriber* who has legal responsibility for the *dependent's* medical care pursuant to a court order, provided *we* are informed of such order. This payment will discharge *us* from all further liability to the extent of the payment made. If the *member* who receives such services is deceased at the time of payment, *we* may at *our* option pay the *provider* of medical services or the *member's* estate.

Bills from *Participating Providers*

When *you* present *your* identification card at the time of requesting services from *participating providers*, paperwork and submission of *post-service claims* relating to services will be handled for *you* by *your participating provider*. *You* may be asked by *your provider* to sign a form allowing *your provider* to submit claims on *your* behalf. If *you* receive an invoice or bill from *your provider* for services before it has been submitted to *us*, simply return the bill or invoice to *your provider*, noting *your* enrollment with *us*. *Your provider* will then submit the *post-service claim* to *us* in accordance with the terms of its participation agreement. *Your post-service claim* will be processed for payment according to *our* guidelines. *We* must receive *post-service claims* within 12 months after the date services were *incurred*, except in the absence of *your* legal capacity. *Post-service claims* received after the deadline will be denied.

Notice of Claim. If *you* receive a bill from *your provider* for services and *you* are directly submitting notice of *your* claim to *us*, *we* encourage *you* to submit written notice of *your* claim to *us* within 20 calendar days after the date the service was *incurred* or as soon as reasonably possibly. This notice should be sent to Aspirus Health Plan, Inc. at PO Box 1890, Southampton, PA 18966-9998.

Proof of Loss and Claim Submission. *We* encourage *you* to submit *your* itemized bill and written proof of loss within 90 calendar days after the date the service was *incurred* or as soon as reasonably possible. In all cases *we* must receive these *post-service claims* within 12 months after the date services were *incurred*, except in the absence of *your* legal capacity. The itemized bill and written proof of loss must document the date of service, the type of service, a specific medical diagnosis and treatment, service or procedure code, *provider* name and itemized charges. *Post-service claims* received after the deadline will be denied.

Bills from *Non-Participating Providers*

Notice of Claim. *We* encourage *you* to submit written notice of *your* claim to *us* within 20 calendar days after the date the service was *incurred* or as soon as reasonably possibly. This notice should be sent to Aspirus Health Plan, Inc. at PO Box 1890, Southampton, PA 18966-9998.

Proof of Loss and Claim Submission. *We* encourage *you* to submit *your* itemized bill and written proof of loss within 90 calendar days after the date the service was *incurred* or as soon as reasonably possible. In all cases *we* must receive these *post-service claims* within 12 months after the date services were *incurred*, except in the absence of *your* legal capacity. The itemized bill and written proof of loss must document the date of service, the type of service, a specific medical diagnosis and treatment, service or procedure code, *provider* name and itemized charges. *Post-service claims* received after the deadline will be denied.

XVI. Initial Benefit Determinations of *Post-Service Claims*

Post-service claims are claims that are filed for payment of benefits to *us* after medical care has been received and are submitted in accordance with *our post-service claim* filing procedures.

If *your attending health care professional* submits a *post-service claim* on *your* behalf, the *attending health care professional* will be treated as *your* authorized representative by *us* for purposes of such claim and associated appeals, unless *you* specifically direct otherwise to Aspirus Health Plan, Inc. within ten business days from *our* notification that an *attending health care professional* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

If *your post-service claim* is denied, *we* will communicate such denial within 30 calendar days after receipt of a *post-service claim* submitted in accordance with the *contract* filing procedures, provided that *we* have all necessary information it needs to make an initial benefit determination. Even if *we* have all information needed to make an initial benefit determination, but *we* determine that an extension is necessary due to matters beyond *our* control, or the control of any associated group *health plan*, because *we* are subject to the requirements of the claims procedures under the US Department of Labor rules at 29 CFR § 2560.503-1 *et seq.*, in accordance with the *Affordable Care Act*, then *we* may extend the time period for *our* initial benefit determination by sending written notice to *you* before the end of the initial 30-calendar day benefit determination period, which describes the circumstances that require the extension. *We* will notify *you* of *our* initial determination within 15 calendar days after the end of the initial 30-calendar day benefit determination period.

If *we* do not have all necessary information needed to make an initial benefit determination, then *we* may extend the time period for making the initial benefit determination by sending written notice to *you* before the end of the initial 30-calendar day determination period, which describes the missing information and provides a grace period to *you* for providing the necessary information of at least 45 calendar days from the date *you* receive the notice. *We* will notify *you* of *our* initial benefit determination within 15 calendar days after the earlier of i) the date on which *we* receive the requested information and ii) the end of the specified grace period, if *we* do not receive the requested information. If *you* do not provide the requested information within the time period specified, *your* claim will be denied. If, however, *you* or *your* authorized representative submit the requested information after the specified grace period ends and within 365 calendar days after the date *you* incurred services (except in the absence of *your* legal capacity), *we* may, but are not required to, reconsider the submitted information; and will not consider information *we* receive more than 365 calendar days after the date *your* services were incurred.

If *your post-service claim* is denied, notification will be provided to *you*. This notice will explain:

1. Information sufficient to identify the claim involved and any information required by law;
2. The reason for the denial;
3. The part of the *contract* upon which it is based;
4. Any additional material or information needed to make the claim acceptable and the reason it is necessary; and
5. The procedure for filing a complaint.

We may not: (1) retrospectively deny or limit coverage of a *health care service* for which prior authorization was not required by the health carrier, unless there is evidence that the *health care service* was provided based on fraud or misinformation; or (2) deny or limit coverage of a *health care service* which the *enrollee* has already received solely on the basis of lack of prior authorization if the service would otherwise have been covered had the prior authorization been obtained.

XVII. Complaints

Complaints About Administrative Operations and Matters

Complaints about administrative operations and matters are complaints that do not involve medical determinations, such as matters involving the scope of coverage under this *contract* and denials, cancellations or non-renewals of coverage. *You* may submit a complaint to *us* either by telephone or in writing within 180 calendar days following the incident or event that was the basis for *your* complaint. If *your* telephone complaint is not resolved to *your* satisfaction within ten calendar days after *we* receive *your* complaint, *you* may submit *your* complaint in writing. *Your* written complaint should include the specific reason for the complaint and provide any supporting documents. Customer Service is available to provide any assistance necessary to complete a written complaint form.

We will notify *you* that *we* received *your* written complaint within 14 calendar days, unless *your* complaint already is resolved. *We* will notify *you* of *our* decision within 30 calendar days from the date that it receives *your* complaint.

In certain circumstances, *we* may take up to 14 additional calendar days to notify *you* of *our* decision. In such cases, *we* will notify *you*, in advance, of the reasons for the extension and the date *you* may expect the final decision.

Complaints About Claims

Complaints about claims are complaints about *our* failure to pay a benefit under this *contract* because of a determination regarding eligibility, or a failure to pay a benefit under this *contract* because of a matter involving a medical determination. If *you* are requesting benefits that require pre-certification (a *pre-service claim*) or are currently receiving services and are requesting an extension of these services (concurrent care claim), *your* request will be handled in accordance with the pre-certification section of this *contract*. If *your* complaint is about a claim for benefits for services received (a *post-service claim*), *your* complaint must be submitted to *us* within 180 calendar days following the initial denial determination.

We will notify *you* of its decision on *your post-service claim* complaint within 30 calendar days from the date that it receives *your* complaint. This time period may be extended for up to an additional 14 calendar days if *we* cannot make a decision due to circumstances outside of *our* control.

XVIII. Internal Appeals Process

During any appeal as described below, *your* coverage will remain in force. *We* must be provided all the information needed to make a decision. If *we* do not have all information needed and cannot obtain complete information from *you* or *your provider* within the time periods set forth below for deciding an appeal, *your* appeal will be denied.

1. **Acute Care Services Appeals.** If *your* request for pre-certification of acute care services is wholly or partially denied and *you* have not received such services or if *you* are currently receiving acute care services and a request for the extension of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request was denied. *Your* appeal can be submitted to *us* in writing, by telephone, or electronically, along with any issues, comments, and additional information, as appropriate. *You* have the right to present written evidence and telephonic testimony as part of the appeals process.

When *you* appeal the initial determination for medical reasons, *we* will arrange for review of the clinical material by a *physician* who holds a current, unrestricted license to practice medicine, has the same or similar medical specialty as a *provider* that typically treats or manages the condition for which pre-certification of acute care services was requested and who did not make the initial determination. As quickly as *your* medical condition requires, but no later than 72 hours of *our* receipt of *your* appeal, *you* and *your attending health care professional* will receive telephone notice of *our* decision, including the specific reasons for it and the procedure for requesting an external review to the extent external review is required by law. This time period may be extended if *we* cannot make a decision due to circumstances outside of *our* control. Written notification will be sent to *you* and *your attending health care professional* within one business day of the determination, or sooner if *your* medical condition requires.

2. **Non-Acute Care Services Appeals.** If *your* request for pre-certification of non-acute care services is wholly or partially denied and *you* have not received such non-acute care services or if *you* are currently receiving non-acute care services and a request for the extension of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request was denied. *Your* appeal can be submitted to *us* in writing, by telephone, or electronically, along with any issues, comments, and additional information, as appropriate. *You* have the right to present written evidence and telephonic testimony as part of the appeals process.

When *you* appeal the initial determination for medical reasons, *we* will arrange for review of the clinical material by a *physician* who holds a current, unrestricted license to practice medicine, has the same or similar medical specialty as a *provider* that typically treats or manages the condition for which pre-certification of non-acute care services was requested and who did not make the initial determination. Within 15 calendar days after *your* appeal is received by *us*, *you* and *your*

attending health care professional will receive written notice of *our* decision, including the specific reasons for it and the procedure for requesting an external review, to the extent that external review is required by law. This time period may be extended for up to an additional four calendar days if *you* agree.

3. **Concurrent Care Services Appeals.** If *your* request for certification extension (concurrent care) is wholly or partially denied, *you* or *your* authorized representative may submit an appeal to *us* on the same basis as described above. Acute concurrent care services appeals submitted to *us* will be reviewed the same as acute care services appeals above. Non-acute concurrent care services appeals submitted to *us* will be reviewed the same as non-acute care services appeals above.
4. **Complaint Appeals.** If *your* complaint regarding an administrative operation or matter or a *post-service claim* is not resolved to *your* satisfaction, then within 60 calendar days after receiving notice that *your* complaint was wholly or partially denied, *you* or *your* authorized representative may request an appeal. *Your* appeal can be submitted to *us* in writing, along with any issues, comments, and additional information as appropriate. If *your* appeal involves a medical determination in its resolution, *you* have the right to present written evidence and telephonic testimony which pertains to the resolution of the medical determination.

Within 30 calendar days after any written appeal requiring a medical determination in its resolution is received by *us*, *you* will receive written notice of *our* decision, including the specific reasons for it and the procedure for requesting an external review to the extent external review is required by law. Within 30 calendar days after any other written appeal is received by *us*, *you* will receive written notice of *our* decision, including the specific reasons for it. These time periods may be extended for up to an additional 14 calendar days if *we* cannot make a decision due to circumstances outside of *our* control.

5. **Access to Relevant Documents.** Upon request and free of charge, *you* have the right to reasonable access to and copies of all documents, records, and other information relevant to *your* appeal. If *we* generate, rely upon, or consider any new or additional evidence in connection with an appeal, or identify any new or additional rationale for a denial in connection with an appeal, it will be provided to *you* so that *you* have a reasonable opportunity to respond.

XIX. External Review Process

An external review organization is an independent entity under contract with the State of Minnesota to review health plan appeals. If *you* or someone acting on *your* behalf has exhausted, or are deemed under applicable law to have exhausted, *our* internal appeals processes as described in the “Internal Appeals Process” section of this *contract*, *you* or *your* authorized representative may file a request for external review with the Minnesota Department of Health. The external review request form is available on the Minnesota Department of Health website, www.health.state.mn.us, or *you* may request the external review form by phone, email or by contacting the Minnesota Department of Health at the address below:

Minnesota Department of Health
Managed Care Systems Section
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5100 or 1-800-657-3916
Email: health.mcs@state.mn.us

You are deemed to have exhausted if *we* waive the exhaustion requirement, *we* fail to substantially comply with the requirements of this section or *you* request an expedited external review at the same time *you* qualify for and request an acute care service appeal.

If *you* want an external review, *you* must request it within six months after the date of *our* denial determination. *You* have the right to request an expedited external review if *you* receive an adverse determination that involves a medical condition for which the standard external review time would seriously jeopardize *your* life or health or jeopardize *your* ability to regain maximum function.

Cases involving fraudulent marketing and agent misrepresentation are not eligible for external review. External review decisions are binding on *us* but are not binding on *you*. *We* may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. The cost of the external review must be borne by *us*.

How to File a Complaint with the Department of Health

You or someone acting on *your* behalf may file a complaint with the Minnesota Department of Health at any time. *You* may reach the Minnesota Department of Health at 651.201.5100 or toll free at 1.800.657.8916, or via email at health.mcs@state.mn.us.

XX. Definitions

<i>Activities of Daily Living</i>	<i>Eating, toileting, transferring, bathing, dressing, walking, and continence.</i>
<i>Acute Care Facility</i>	A facility that provides care to <i>you</i> when <i>you</i> are in the acute phase of a <i>sickness</i> or <i>injury</i> and will probably have a stay of less than 30 calendar days.
<i>Affordable Care Act</i>	The federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance and regulations issued under these acts.
<i>Ancillary Services</i>	Subject to changes made by the U.S. Department of Health and Human Services, <i>ancillary services</i> are, with respect to a <i>hospital</i> or ambulatory surgical center, which is a <i>participating provider</i>: 1. <i>health care services</i> related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a <i>physician</i> or non-<i>physician</i> practitioner, and <i>health care services</i> provided by assistant surgeons, hospitalists, and intensivists; 2. diagnostic services (including radiology and laboratory services); and 3. <i>health care services</i> provided by a <i>non-participating provider</i> if there is no <i>participating provider</i> who can furnish such <i>health care services</i> at such <i>hospital</i> or ambulatory surgical center.
<i>At Risk for Ovarian Cancer</i>	Means the following: 1. Having a family history: a. with one or more first- or second-degree relatives with ovarian cancer; b. of clusters of women relatives with breast cancer; or c. of nonpolyposis colorectal cancer; or 2. Testing positive for BRCA1 or BRCA2 mutations.
<i>Attending Health Care Professional</i>	The health care professional providing care within the scope of the professional's practice and with primary responsibility for the care provided to <i>you</i> . <i>Attending health care professional</i> shall include only <i>physicians</i> ; chiropractors; <i>dentists</i> ; mental health professionals; podiatrists; and advanced practice nurses.
<i>Bariatric Surgery</i>	Surgery and related expenses for the treatment of obesity.
<i>Bathing</i>	Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
<i>Biofeedback</i>	The technique of making unconscious or involuntary bodily processes (such as heartbeat or brain waves) perceptible to the senses in order to manipulate them by conscious mental control.
<i>Bone Anchored Hearing Aid</i>	A surgically implantable system for treatment of hearing loss that works through direct bone conduction.
<i>Calendar Year</i>	The 12-month period beginning January 1 and ending the following December 31.
<i>Chronic Health Condition</i>	A condition is a condition that is expected to last one year or more and: 1. requires ongoing medical attention to effectively manage the condition or prevent an adverse health event; or 2. limits one or more <i>activities of daily living</i>.
<i>Chronic Disease</i>	Diabetes, asthma, and allergies requiring the use of epinephrine-auto-injectors as defined in Minnesota Statutes §62Q.481.

Clinical Trial

A phase I, phase II, phase III, or phase IV *clinical trial* that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The *clinical trial* must meet one of the following:

1. Federally-funded *clinical trial* in which the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - a. National Institutes of Health.
 - b. Centers for Disease Control and Prevention.
 - c. Agency for Health Care Research and Quality.
 - d. Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in paragraphs a. through d. above or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. If the clinical study or investigation is conducted by the Department of Veterans Affairs, Department of Defense, or the Department of Energy, has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and there has been an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. A study or investigation conducted under an investigational new drug application reviewed by the FDA.
3. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Cochlear Implant

An implantable instrument or device that is designed to enhance hearing.

Coinsurance

A portion of *eligible charges* that is paid by *you* and a separate portion that is paid by *us* for *covered services* and supplies. *Your coinsurance* is a percentage of those *eligible charges* that are the 1) discounted charges that are negotiated with the *participating provider* and calculated at the time the claim is processed; 2) the *non-participating provider reimbursement value*, or 3) the amount *you* must pay after satisfying *your deductible* for *emergency services* provided by a *non-participating provider*.

Combination Drugs

A *prescription drug* in which two or more chemical entities are combined into one commercially available dosage form.

Complex Home Care Nursing

Home care nursing services provided to *you* if *you* meet the criteria for regular *home care nursing* and require life-sustaining interventions to reduce the risk of long-term injury or death.

Compounded Drugs

Customized medications prepared by a pharmacist from scratch using raw chemicals, powders and devices according to a *physician's* specifications to meet *your* needs.

Comprehensive Postnatal Visit

A visit with a health care *provider* that includes a full assessment of the mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

Confinement

An uninterrupted stay of 24 hours or more in a *hospital*, *skilled nursing facility*, *rehabilitation facility*, or licensed *residential treatment facility*.

Continence

Ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

<i>Continuing Care Patient</i>	A <i>continuing care patient</i> means an individual is, with respect to a <i>provider</i>: 1. Undergoing a course of treatment for a <i>serious and complex condition</i> from the <i>provider</i>; 2. Undergoing a course of institutional or inpatient care from the <i>provider</i>; 3. Scheduled to undergo non-elective surgery from the <i>provider</i>; 4. Pregnant and undergoing a course of treatment for the pregnancy from the <i>provider</i>; or 5. Terminally ill and receiving treatment for such illness from the <i>provider</i>.
<i>Contract</i>	The legal agreement between the <i>subscriber</i> and <i>us</i> relating to the provision of <i>health care services</i> , which consists of this document and any amendments.
<i>Convenience Care Center</i>	A health care clinic whose primary purpose is to provide immediate treatment for the diagnosis of minor conditions.
<i>Conversion Therapy</i>	Any practice by a mental health practitioner or mental health professional that seeks to change a person's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward people regardless of gender. <i>Conversion therapy</i> does not include counseling that provides assistance to a person undergoing gender transition. It also does not include counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change the person's sexual orientation or gender identity.
<i>Copayment</i>	The fixed amount of <i>eligible charges</i> you must pay to the <i>provider</i> for covered <i>health care services</i> received. The <i>copayment</i> may not exceed the charge billed for the covered <i>health care services</i> .
<i>Cosmetic</i>	Services and procedures that improve physical appearance but do not correct or improve a physiological function and are not <i>medically necessary</i> .
<i>Covered Services</i>	Services or supplies that are provided by <i>your</i> licensed <i>provider</i> or clinic and covered by <i>us</i> , subject to all of the terms, conditions, limitations and exclusions of the <i>contract</i> .
<i>Custodial Care</i>	Services to assist in <i>activities of daily living</i> and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, <i>bathing</i> , and <i>eating</i> .
<i>Deductible</i>	The amount of <i>eligible charges</i> that <i>you</i> must <i>incur</i> and pay in a <i>calendar year</i> before <i>we</i> will pay benefits.
<i>Dental Specialist</i>	A <i>dentist</i> board eligible or certified in the areas of endodontics, <i>oral surgery</i> , orthodontics, pedodontics, periodontics, and prosthodontics.
<i>Dentist</i>	A licensed doctor of dental surgery or dental medicine, lawfully performing dental services in accordance with governmental licensing privileges and limitations.
<i>Dependent(s)</i>	The <i>subscriber's</i> spouse or children as described in the "Eligibility, Enrollment, and <i>Effective Date</i> " section.
<i>Designated Transplant Network Provider</i>	Any licensed <i>hospital</i> , health care <i>provider</i> , group or association of health care <i>providers</i> that satisfies the quality, outcome, and accessibility needs of <i>us</i> and <i>our members</i> , and has contracted to participate as a designated transplant <i>provider</i> in the specific <i>participating provider</i> network designated by <i>us</i> to provide benefits for organ or bone marrow transplant or stem cell support and all related services and aftercare for <i>you</i> .
<i>Dressing</i>	Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
<i>Eating</i>	Feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.

<i>Educational</i>	A service or supply: (1) that is primarily intended to provide training in the <i>activities of daily living</i> , instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or (2) that is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental, or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending <i>physician</i> .
<i>Effective Date</i>	The date <i>you</i> become eligible for health care benefits under this <i>contract</i> and complete all enrollment requirements.
<i>Eligible Charges</i>	A charge for <i>health care services</i> subject to all of the terms, conditions, limitations and exclusions of the <i>contract</i> and for which <i>we</i> or <i>you</i> will pay.
<i>Emergency (Also Emergency Medical Condition)</i>	See definition of <i>emergency medical condition</i> .
<i>Emergency Department of a Hospital</i>	A <i>hospital</i> outpatient department that provides <i>emergency services</i> .
<i>Emergency Medical Condition (Also Emergency)</i>	A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. serious impairment to bodily functions; or 3. serious dysfunction of any bodily organ or part.

Emergency Services

1. With respect to an *emergency medical condition*:
 - a. A medical screening examination that is within the capability of the *emergency department of a hospital* or of an *independent freestanding emergency department*, as applicable, including *ancillary services* routinely available to the emergency department to evaluate such *emergency medical condition*; and
 - b. Within the capabilities of the staff and facilities available at the *hospital* or the *independent freestanding emergency department*, as applicable, such further medical examination and treatment to *stabilize* the patient (regardless of the department of the *hospital* in which such further examination or treatment is furnished).
2. Inclusion of additional services:
 - a. Unless each of the conditions described in subclause b. are met, items and services:
 - i. Which are *covered services*; and
 - ii. That are furnished by a *non-participating provider* or non-participating emergency facility (regardless of the department of the *hospital* in which such items or services are furnished) after *you* are *stabilized* and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause 1. are furnished.
 - b. Conditions. If *you* are *stabilized* and furnished additional items and services described in subclause a. after such stabilization by a *provider* or facility described in subclause a., the conditions are the following:
 - i. Such *provider* or facility determines *you* are able to travel using non-medical transportation or non-emergency medical transportation.
 - ii. Such *provider* furnishing such additional items and services satisfies the notice and consent criteria required by federal law with respect to such items and services.
 - iii. *You* are in a condition to receive the information provided in the notice and to provide informed consent, in accordance with applicable federal and state law.
 - iv. Any other conditions required by law, such as conditions relating to coordinating care transitions to *participating providers* and facilities.

Enrollee

A *qualified individual* enrolled in a *qualified health plan*.

Essential Health Benefits

The categories of *covered services* this *contract* is required to cover under the *Affordable Care Act*, which include:

1. Ambulatory patient services;
2. *Emergency services*;
3. Hospitalization;
4. Laboratory services;
5. Maternity and newborn care;
6. Mental health and substance use disorder services, including behavioral health treatment;
7. Pediatric services, including oral and vision care;
8. *Prescription drugs*;
9. *Preventive health care services*, wellness services, and chronic disease management services.
10. *Rehabilitative care* and *habilitative care* services and devices; and
11. Additional essential health benefits included in the EHB benchmark plan, as defined under the *Affordable Care Act*.

Fee-for-Service

Method of payment for *provider* services based on each visit or service rendered.

Fee Schedule

The amount that the *participating provider* has contractually agreed to accept as reimbursement in full for *covered services* and supplies. This contracted amount may be less than the *provider's* usual charge for the service.

If *health care services* are delivered to *you* via *telehealth* by a distant site *participating provider* who is **not** a designated *participating provider* for *virtual care*, we will reimburse such *participating provider* on the same basis and using the same *fee schedule* as would apply if the *covered services* had been delivered in person by the distant site *participating provider*.

<i>Formulary</i>	A list, which may change from time to time, of <i>prescription drugs</i> which <i>we</i> , in <i>our</i> sole discretion, have established for use with this <i>contract</i> .
<i>Gender-Affirming Care</i>	<i>Gender-affirming care</i> means all medical, surgical, counseling, or referral services, including <i>telehealth</i> services, that an individual may receive to support and affirm the individual's gender identity or gender expression and that are legal under the laws of Minnesota.
<i>Geographical Service Area</i>	The region in which <i>we</i> operate and <i>your contract</i> is available, as determined by <i>us</i> . Please see www.aspirushealthplan.com for more information.
<i>Habilitative Care</i>	<i>Health care services</i> that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
<i>Health Care Services</i>	Medical or behavioral services including pharmaceuticals, devices, technologies, tests, treatments, therapies, supplies, procedures, hospitalizations, or <i>provider</i> visits.
<i>Hearing aid</i>	Any instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except its batteries and cords. This includes both externally wearable and implantable devices, including <i>cochlear implants</i> and <i>bone anchored hearing aids</i> .
<i>Home Care</i>	<i>Health care services</i> provided directly to <i>you</i> in <i>your</i> home under a written plan that meets the following criteria: (1) the plan is developed by <i>your attending health care professional</i> ; (2) the plan is approved by <i>your attending health care professional</i> in writing; (3) the plan is reviewed by <i>your attending health care professional</i> every two months (or less frequently if <i>your provider</i> believes and <i>we</i> agree that less frequent reviews are enough); and (4) <i>home care</i> is provided or coordinated by a home health agency or certified rehabilitation agency that is licensed by the Department of Health or certified by Medicare.
<i>Home Care Nursing</i>	Ongoing hourly nursing ordered by a <i>physician</i> , advanced practice registered nurse, or physician assistant and services performed by a registered nurse or licensed practical nurse within the scope of practice as defined by the Minnesota Nurse Practice Act under Minnesota Statutes sections 148.171 to 148.285, in order to maintain or restore a person's health.
<i>Home Health Aide Services</i>	Services performed by a home health aide which: (1) are not required to be performed by a registered nurse or licensed practical nurse; and (2) primarily aid the patient in performing normal <i>activities of daily living</i> , which may include <i>custodial care</i> .
<i>Homebound</i>	When <i>you</i> are unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute <i>homebound</i> status.
<i>Hospital</i>	A facility that provides diagnostic, medical, therapeutic, and surgical services by or under the direction of <i>physicians</i> and with 24-hour registered nursing services. The <i>hospital</i> is not mainly a place for rest or <i>custodial care</i> and is not a nursing home or similar facility.
<i>Incurred</i>	Services and supplies rendered to a <i>member</i> are considered to be " <i>incurred</i> " at the time or date the service or supply was actually purchased or provided.
<i>Independent Freestanding Emergency Department</i>	A health care facility that: 1. is geographically separate and distinct and licensed separately from a <i>hospital</i> under applicable State law; and 2. provides any of the <i>emergency services</i> listed in section 1. of the definition of <i>emergency services</i>.

<i>Infertility</i>	Inability or diminished ability to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination: 1. One year, if <i>you</i> are a female under age 35 or a male of any age, or 2. Six months, if <i>you</i> are a female age 35 or older, provided that <i>your infertility</i> is not related to voluntary sterilization or failed reversal of voluntary sterilization; or Inability or diminished ability to produce offspring, including but not limited to a woman's repeated failure to carry a pregnancy to fetal viability. Repeated failures to carry a pregnancy to fetal viability means three consecutive documented spontaneous abortions in the first or second trimester. Such inability must be documented by <i>your provider</i>.
<i>Infertility Treatment/Fertility Treatment</i>	A <i>health care service</i> that is intended to (1) promote or preserve fertility; or (2) achieve and maintain a condition of pregnancy. For purposes of this definition, <i>infertility</i> or <i>fertility treatment</i> includes, but is not limited to: 1. <i>Fertility</i> tests and <i>prescription drugs</i>. 2. Tests and exams done to prepare for or follow through with induced conception. 3. Surgical reversal of a sterilized state that was a result of a previous surgery. 4. Sperm enhancement procedures. 5. Direct attempts to cause or maintain pregnancy by any means including, but not limited to: Hormone therapy or <i>prescription drugs</i>; artificial insemination; in vitro insemination; GIFT or ZIFT; embryo transfer; and freezing and/or storage of embryo, eggs, or semen.
<i>Injury</i>	Bodily damage other than <i>sickness</i> , including all related conditions and recurrent symptoms.
<i>Investigative</i>	As determined by <i>us</i>, a drug, device or medical treatment or procedure is <i>investigative</i> if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. <i>We</i> will consider the following categories of reliable evidence, none of which shall be determinative by itself: 1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the FDA; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and 2. Whether there are consensus opinions or recommendations in relevant scientific and <i>medical literature</i>, peer-reviewed journals, or reports of <i>clinical trial</i> committees and other technology assessment bodies. This includes consideration of whether an oncology treatment is included in the applicable National Comprehensive Cancer Network (NCCN) guideline, as appropriate for its proposed use, or whether a drug is included in any authoritative compendia as identified by the Medicare program such as, the National Comprehensive Cancer Network Drugs and Biologics Compendium, as appropriate for its proposed use; and 3. Whether there are consensus opinions of national and local health care <i>providers</i> in the applicable specialty as determined by a sampling of <i>providers</i>, including whether there are protocols used by the treating facility or another facility, studying the same drug, device, medical treatment or procedure.
<i>Maintenance Care</i>	Care that is not habilitative or rehabilitative therapy and there is lack of documented significant progress in functional status over a reasonable period of time.
<i>Medical Literature</i>	Articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review <i>medical literature</i> . Each article must use generally accepted scientific standards and must not use case reports to satisfy this criterion.

<i>Medically Necessary</i>	Any <i>health care services</i>, <i>preventive health care services</i>, and other preventive services that <i>we</i>, in <i>our</i> discretion and on a case by case basis, determine are appropriate and necessary in terms of type, frequency, level, setting, and duration, for the diagnosis or condition; and the care must: 1. Be consistent with the medical standards and generally accepted practice parameters of <i>providers</i> in the same or similar general specialty as typically manages the condition procedure or treatment at issue; and 2. Help restore or maintain <i>your</i> health; or 3. Prevent deterioration of <i>your</i> condition; or 4. Prevent the reasonably likely onset of a health problem or detect an incipient problem.
<i>Member</i>	A <i>subscriber</i> or <i>dependent</i> who is enrolled under this <i>contract</i> .
<i>Minimum Essential Coverage</i>	Health care coverage as defined by the <i>Affordable Care Act</i> and codified in the Internal Revenue Code § 5000A(f), and any related regulations as they may be amended from time-to-time; which includes, but is not limited to, certain government-sponsored programs including a standard basic health plan (BHP) within the meaning of the <i>Affordable Care Act</i> , employer-sponsored plans, <i>health plans</i> offered in the individual market in a state; and which, if it is an employer-sponsored plan, provides minimum value, meaning that the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs.
<i>Net price</i>	<i>Our</i> cost for insulin, including any rebates or discounts received by or accrued directly or indirectly to Aspirus Health Plan, Inc. from a drug manufacturer or pharmacy benefit manager.
<i>Non-Participating Provider</i>	1. A <i>physician</i> or other health care <i>provider</i> who, when providing <i>health care services</i>, is acting within the scope of practice of that <i>provider's</i> license or certification under applicable State law; or 2. A facility, like a clinic or <i>hospital</i>; that is not a <i>participating provider</i>.
<i>Non-Participating Provider Benefits</i>	Coverage for <i>health care services</i> provided by licensed <i>providers</i> other than <i>participating providers</i>. With <i>non-participating provider benefits</i>, <i>you</i> may be financially responsible for a <i>deductible</i>, <i>coinsurance</i>, and any amount in excess of the <i>non-participating provider reimbursement value</i>. Note that <i>we</i> may attempt to negotiate a discount with a <i>non-participating provider</i>. Such negotiation, if successful, does not change the <i>provider's</i> status from a <i>non-participating provider</i> to a <i>participating provider</i>.
<i>Non-Participating Provider Reimbursement Value</i>	The amount that will be paid by <i>us</i> to a <i>non-participating provider</i> for a non-emergency service is the least of the following: 1. a percentage of the <i>non-participating provider's</i> charge; 2. a percentage of an amount based on prevailing reimbursement rates or marketplace charges, for similar services and supplies, in the geographic area; 3. a percentage of the amount agreed upon between <i>us</i> and the <i>non-participating provider</i>; or 4. a percentage of the Medicare or other federal government program allowed amount in the geographic area in which the service is performed. If one or more of the above options for determining the <i>non-participating provider reimbursement value</i> is not readily available, <i>we</i> may, at <i>our</i> discretion, determine the <i>non-participating provider reimbursement value</i> based on the least of the remaining options. If the amount billed by the <i>non-participating provider</i> is greater than the <i>non-participating provider reimbursement value</i>, <i>you</i> must pay the difference. This amount is in addition to any <i>deductible</i> or <i>coinsurance</i> amount <i>you</i> may be responsible for according to the terms of this <i>contract</i>. If <i>health care services</i> are delivered to <i>you</i> via <i>telehealth</i> by a distant site <i>non-participating provider</i>, <i>we</i> will reimburse such <i>non-participating provider</i> on the same basis and at the same <i>non-participating provider reimbursement value</i> as would apply if the <i>covered services</i> had been delivered in person by the distant site <i>non-participating provider</i>.

<i>Oral Surgery</i>	Surgical services performed within the oral cavity.
<i>Orthognathic surgery</i>	Surgical manipulation of the elements of the facial skeleton to restore the proper anatomic and functional relationship in patients with dentofacial skeletal anomalies.
<i>Orthosis</i>	- an external medical device that is: - custom-fabricated or custom-fitted to a specific patient based on the patient's unique physical condition; - applied to a part of the body to correct a deformity, provide support and protection, restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or postoperative condition; and - deemed <i>medically necessary</i> by a prescribing <i>physician</i> or licensed health care provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services; and - any provision, repair, or replacement of a device that is furnished or performed by: - an accredited facility in comprehensive orthotic services; or - a health care provider licensed in Minnesota and operating within the provider's scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies, or services.
<i>Orthotics</i>	- the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing and providing the initial training necessary to accomplish the fitting of an orthotic device for the support, correction, or alleviation of a neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity; - evaluation, treatment, and consultation related to an orthotic device; - basic observation of gait and postural analysis; - assessing and designing <i>orthosis</i> to maximize function and provide support and alignment necessary to prevent or correct a deformity or to improve the safety and efficiency of mobility and locomotion; - continuing patient care to assess the effect of an orthotic device on the patient's tissues; and - proper fit and function of the orthotic device by periodic evaluation.
<i>Out-of-Network Rate</i>	The term ‘<i>out-of-network rate</i>’ means, with respect to <i>emergency services</i> provided by a <i>non-participating provider</i>: - Subject to clause 3., the amount determined in accordance with any state law in effect in the state where such <i>emergency services</i> were provided; - Subject to clause 3., if no such state law which would determine the amount under clause 1. is in effect: - Subject to subclause b., the amount agreed to by Aspirus Health Plan, Inc. and the <i>non-participating provider</i>; or - If Aspirus Health Plan, Inc. and the <i>non-participating provider</i> enter the independent dispute resolution (IDR) process under the No Surprises Act and do not agree on an amount before a certified IDR entity makes a determination on the amount to be paid to the <i>non-participating provider</i>, then the amount determined by the certified IDR entity; or - In the case the state has an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such All-Payer Model Agreement for such <i>emergency services</i> provided by the <i>non-participating provider</i>.
<i>Out-of-Pocket Limit</i>	The maximum amount of money <i>you</i> must pay in <i>copayments</i>, <i>coinsurance</i> and <i>deductible</i> before <i>we</i> pay remaining <i>eligible charges</i>. If <i>you</i> reach benefit, day, or visit maximums, <i>you</i> are responsible for amounts that exceed the <i>out-of-pocket limit</i>.

<i>Participating Provider</i>	1. A <i>physician</i> or other health care <i>provider</i> who is acting within the scope of practice of that <i>provider's</i> license or certification under applicable State law; or 2. A facility, like a <i>hospital</i> or clinic; that is directly contracted to participate in the specific <i>participating provider</i> network designated by <i>us</i> to provide benefits to <i>members</i> enrolled in this <i>contract</i>. The participating status of <i>providers</i> may change from time to time. <i>Participating providers</i> may also be offered from other Preferred Provider Organizations that have contracted with <i>us</i>. Note that <i>we</i> may attempt to negotiate a discount with a <i>non-participating provider</i>. Such negotiation, if successful, does not change the <i>provider's</i> status from a <i>non-participating provider</i> to a <i>participating provider</i>.
<i>Participating Provider Benefits</i>	Coverage for <i>health care services</i> provided through <i>participating providers</i> .
<i>Pediatric acute-onset neuropsychiatric syndrome (PANS)</i>	A class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.
<i>Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)</i>	A condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.
<i>Physical Disability</i>	A condition caused by a physical <i>injury</i> or congenital defect to one or more parts of <i>your</i> body that is expected to be ongoing for a continuous period of at least two years from the date the initial proof is supplied to <i>us</i> and as a result <i>you</i> are incapable of self-sustaining employment and are dependent on the <i>subscriber</i> for a majority of support and maintenance. An illness by itself will not be considered a <i>physical disability</i> unless adequate separate proof is furnished to <i>us</i> that allows <i>us</i> to determine that a <i>physical disability</i> also exists as defined in the preceding sentence.
<i>Physician</i>	A licensed Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Optometry, or Doctor of Chiropractic.
<i>Post-Service Claim</i>	A request for payment of benefits that is made by <i>you</i> or <i>your</i> authorized representative after services are rendered and in accordance with the procedures described in this <i>contract</i> .
<i>Pre-Service Claim</i>	A claim related to services that have not yet been received and require a request for prior authorization for services that is made by <i>you</i> or <i>your</i> authorized representative in accordance with the procedures described in this <i>contract</i> .
<i>Premium</i>	The total payment that <i>we</i> require be paid by <i>you</i> or on <i>your</i> behalf for the provision of the <i>covered services</i> listed in this <i>contract</i> .
<i>Prescription Drug</i>	A drug approved by the FDA for use only as prescribed by a <i>provider</i> properly authorized to prescribe that drug.
<i>Preventive Health Care Services</i>	The <i>covered services</i> that are described in the Preventive Contraceptive Methods and Counseling for Women section and the <i>Preventive Health Care Services</i> section of this <i>contract</i> .
<i>Primary Care Practitioner (PCP)</i>	A doctor of medicine, physician assistant or nurse practitioner who is licensed or otherwise qualified under applicable law, who provides primary care services in the family medicine, general practice, internal medicine, OB/GYN or pediatrics areas of medical practice.

<i>Prosthesis</i>	1. an external medical device that is: a. used to replace or restore a missing limb, appendage, or other external human body part; and b. deemed <i>medically necessary</i> by a prescribing <i>physician</i> or licensed health care provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services; and 2. any provision, repair, or replacement of a device that is furnished or performed by: a. an accredited facility in comprehensive prosthetic services; or b. a health care provider licensed in Minnesota and operating within the provider's scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies, or services.
<i>Prosthetics</i>	1. the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a <i>prosthesis</i> through the replacement of external parts of a human body lost due to amputation or congenital deformities or absences; 2. the generation of an image, form, or mold that replicates the patient's body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial appendage that is designed either to support body weight or to improve or restore function or anatomical appearance, or both; 3. observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the <i>prosthesis</i> to maximize function, stability, and safety of the patient; 4. providing and continuing patient care in order to assess the prosthetic device's effect on the patient's tissues; and 5. assuring proper fit and function of the prosthetic device by periodic evaluation.
<i>Provider</i>	A health care professional, <i>physician</i> , or facility licensed, certified, or otherwise qualified under state law that delivers the <i>health care services</i> to you.
<i>Qualified Health Plan</i>	Health insurance coverage or a group health plan that MNsure certifies meets the criteria for certification required under the <i>Affordable Care Act</i> ; that provides <i>essential health benefits</i> ; and is offered by a health insurance issuer that meets the requirements of Section 1301(a)(1)(c) of the <i>Affordable Care Act</i> , and any related regulations as they may be amended from time-to-time.
<i>Qualified Individual</i>	An individual whom MNsure, determines has met the eligibility requirements for enrollment in a <i>qualified health plan</i> in the individual market, which requirements include, but are not limited to, citizenship, national status, or lawful presence in the United States; residency in a service area served by this <i>contract</i> ; and not being incarcerated. Such residency requirement does not apply to <i>dependents</i> . An individual who, at the time of enrollment, is incarcerated, other than incarceration pending the disposition of charges, is not a <i>qualified individual</i> .
<i>Qualifying Payment Amount</i>	The calculation for this amount is to be determined in accordance with the applicable federal regulation. Call Customer Service for further information.
<i>Rapid Whole Genome Sequencing (rWGS)</i>	"Rapid whole genome sequencing" or "rWGS" means an investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results in 14 days. Rapid whole genome sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

<i>Rare Disease</i>	"Rare disease" means any disease or condition that meets any of the following criteria. 1. Affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening; 2. Affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to 21 U.S.C. § 360bb; 3. Labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or, 4. For which an <i>enrollee</i> has (a) received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint, (b) has documentation in the <i>enrollee's</i> medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and, (c) had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses. A <i>rare disease</i> or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.
<i>Recognized Amount</i>	With respect to an item or service furnished by a <i>non-participating provider</i>: 1. Subject to clause 3., in the case of such item or service furnished in a state that has in effect a law that determines the amount to be paid for such item or service; 2. Subject to clause 3., in the case of such item or service furnished in a state that does not have in effect such a state law, the amount that is the <i>qualifying payment amount</i>; or 3. In the case of such item or service furnished in a state with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such system for such item or service.
<i>Reconstructive</i>	<i>Medically necessary</i> surgery to restore or correct: 1. a defective body part, when such defect is incidental to or resulting from <i>injury</i>, <i>sickness</i>, or prior surgery of the involved body part; or 2. a congenital disease or anomaly which has resulted in a functional defect as determined by a <i>physician</i>.
<i>Reconstructive Surgery Following a Mastectomy</i>	Coverage for <i>members</i> receiving <i>covered services</i> under this <i>contract</i> in connection with a mastectomy and who elect breast reconstruction in connection with such mastectomy will include: 1. all stages of reconstruction of the breast on which the mastectomy has been performed if the mastectomy was determined to be <i>medically necessary</i> by the attending <i>physician</i>; 2. surgery and reconstruction of the other breast to produce symmetrical appearance; 3. <i>prostheses</i>; and 4. treatment of physical complications at all stages of mastectomy, including lymphedemas.
<i>Rehabilitative Care</i>	<i>Health care services</i> that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled within a period of time to meet a <i>member's</i> maximum potential ability to perform functional daily living activities. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings, unless such services are for chronic medical conditions or long-term disabilities, where progress toward such functional ability maintenance and improvement is not anticipated. Also not considered <i>rehabilitative care</i> are <i>skilled nursing facility</i> care and home health services.
<i>Related Medical Supplies</i>	Syringes, insulin pens, insulin pumps, test strips, glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and other medical supply items necessary to effectively and appropriately treat a <i>chronic disease</i> or administer a <i>prescription drug</i> prescribed to treat a <i>chronic disease</i>.

<i>Rescission</i>	A cancellation or termination of coverage that has retroactive effect. A cancellation or termination of coverage is not a <i>rescission</i> if: 1. the cancellation or termination has only a prospective effect, 2. the cancellation or termination is caused by <i>your</i> failure to timely pay <i>your</i> required <i>premiums</i>, or 3. the cancellation or termination is requested by <i>you</i> or <i>your</i> authorized representative and <i>we</i>, in <i>our</i> sole discretion, agree to allow such request.
<i>Residential Treatment Facility</i>	A facility that is licensed by the appropriate state agency and that provides 24 hour a day care, supervision, food, lodging, rehabilitation, or treatment for <i>sickness</i> related to mental health and substance use disorders.
<i>Risk Allowance and Risk Sharing</i>	<i>Risk allowance</i> means that a percentage of the reimbursement to a <i>participating provider</i> is held back, paid or prepaid, as applicable. The amount withheld, paid or prepaid generally will be less than 20% of the <i>fee schedule</i> amount. <i>Risk sharing</i> is a <i>participating provider</i> payment method in which certain per <i>member</i> per month or alternative cost or performance targets are agreed to and, at the end of a period, the parties to the arrangement share in some or the entire amount by which the actual costs, savings or performance exceed or are less than the target.
<i>Routine Patient Costs</i>	The cost of any <i>covered services</i> that would typically be covered if <i>you</i> were not enrolled in an approved <i>clinical trial</i>. <i>Routine patient costs</i> do not include: 1. the cost of the <i>investigative</i> item, device, or service that is the subject of the approved <i>clinical trial</i>. 2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management. 3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
<i>Serious and Complex Condition</i>	<i>Serious and complex condition</i> means, with respect to a <i>member</i>: 1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or 2. In the case of a chronic illness or condition, a condition that: a. Is life-threatening, degenerative, potentially disabling, or congenital; and b. Requires specialized medical care over a prolonged period of time.
<i>Sickness</i>	Includes physical or mental illness or disease.
<i>Skilled Care</i>	Nursing or <i>skilled rehabilitation</i> services requiring the skills of technical or professional medical personnel to provide care or assess the <i>member's</i> changing condition. Long term dependence on respiratory support equipment does not in and of itself define a need for <i>skilled care</i> .
<i>Skilled Nursing Facility</i>	A Medicare licensed bed or facility (including an extended care facility, <i>hospital</i> swing-bed, and transitional care unit) that provides <i>skilled care</i> .
<i>Skilled Rehabilitation</i>	<i>Skilled rehabilitation</i> is a type of <i>skilled care</i> that helps people recover from an <i>injury</i> , surgery or <i>sickness</i> provided by health care professionals who can perform or supervise <i>skilled nursing</i> or therapy. The goal of <i>skilled rehabilitation</i> is to help <i>you</i> return to normal life and live as independently as possible.
<i>Specialist</i>	<i>Providers</i> other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics.
<i>Specialty Drugs</i>	Injectable and non-injectable <i>prescription drugs</i>, as determined by <i>us</i>, which have one or more of the following key characteristics: 1. frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes; 2. intensive patient training and compliance assistance are required to facilitate therapeutic goals; 3. there is limited or exclusive product availability and/or distribution; 4. there are specialized product handling, storage and/or administration requirements; or 5. are produced by living organisms or their products.

<i>Stabilize, To</i>	With respect to an <i>emergency medical condition</i> , to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an <i>emergency</i> condition involving a pregnant woman who is having contractions, to deliver (including the placenta).
<i>Standard Reference Compendia</i>	Any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.
<i>Stepchild(ren)</i>	A natural or adopted child of the <i>subscriber's</i> lawful spouse.
<i>Subscriber</i>	The individual who submits an application for coverage, which may include application for coverage of any eligible <i>dependents</i> that the <i>subscriber</i> wishes to enroll, and, at the time of such application, is responsible for payment of <i>premium</i> and is not entitled to Part A or enrolled in Part B of Medicare.
<i>Telehealth</i>	“ <i>Telehealth</i> ” means the delivery of <i>health care services</i> or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient’s health care. <i>Telehealth</i> includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care <i>provider</i> located at a distant site. <i>Telehealth</i> also includes audio-only communication between a health care <i>provider</i> and a patient if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. <i>Telehealth</i> does not include communication between health care <i>providers</i> that consists solely of a telephone conversation, e-mail, or facsimile transmission. <i>Telehealth</i> does not include communication between a health care <i>provider</i> and a patient that consists solely of an e-mail or facsimile transmission. <i>Telehealth</i> does not include telemonitoring services which means the remote monitoring of clinical data related to the <i>enrollee's</i> vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care <i>provider</i> for analysis.
<i>Toileting</i>	Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
<i>Transferring</i>	Moving into or out of a bed, chair or wheelchair.
<i>Transplant Services</i>	Transplantation (including retransplants) of the human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.
<i>Unauthorized Provider Services</i>	<i>Unauthorized provider services</i> are incurred when a <i>member</i> receives <i>health care services</i>: - From a <i>non-participating provider</i> in a <i>participating hospital</i> or ambulatory surgical center, when the services are rendered - due to the unavailability of a <i>participating provider</i>; - by a <i>non-participating provider</i> without the <i>enrollee's</i> knowledge; or - due to the need for unforeseen services arising at the time the services are being rendered; or - From a <i>participating provider</i> that sends a specimen taken from the <i>member</i> in the <i>participating provider's</i> practice setting to a non-participating laboratory, pathologist, or other medical testing facility; The services described in clause 2, are not <i>unauthorized provider services</i> if the <i>member</i> gives advance written consent to the <i>provider</i> acknowledging that the use of the <i>provider</i>, or the <i>services</i> to be rendered, may result in costs not covered by <i>us</i>. <i>Unauthorized provider services</i> do not include <i>emergency services</i> as defined herein and in Minnesota § 62Q.55, subdivision 3.
<i>Urgent Care Center</i>	A licensed health care facility that is designed primarily to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.

<i>Virtual Care</i>	Care provided by <i>our</i> designated <i>virtual care</i> vendor, MDLive. Such care is performed without physical face to face interaction, but through electronic communication allowing evaluation, assessment and the management of services that leads to a treatment plan. <i>You</i> can access MDLive at MDLIVE.com/AspirusHealthPlan.
<i>We, Us, Our</i>	Refers to Aspirus Health Plan, Inc..
<i>You, Your, Yourself</i>	Refers to <i>member</i> .

Notice Concerning Policyholder Rights in an Insolvency Under the Minnesota Life and Health Insurance Guaranty Association Law

If the insurer that issued *your* life, annuity, or health insurance policy becomes impaired or insolvent, *you* are entitled to compensation for *your* policy from the assets of that insurer. The amount *you* recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association

3300 Wells Fargo Center

90 South 7th Street

Minneapolis, MN 55402

Telephone Number: 612.322.8713; Fax Number: 402.474.5393; info@mnlifeqa.org.

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$500,000. Subject to this \$500,000 limit, the guaranty association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, \$410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If *your* claim exceeds the guaranty association's limits, *you* may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, *YOU* SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

Notice to *Enrollee*

Your Rights Related to Your Mental Health and Substance Use Disorder Benefits

The Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equity Act of 2008, the *Affordable Care Act* and Minnesota Statutes § 62Q.47 give *you* certain rights related to *your* mental health and substance use disorder (MH/SUD) benefits. In general, *your* MH/SUD benefits must be substantially the same as *your* medical and surgical (Med/Surg) benefits.

Your coverage for MH/SUD benefits and Med/Surg benefits must be subject to substantially the same cost-sharing requirements. In addition, *your* coverage cannot contain a cost-sharing requirement that applies to MH/SUD benefits but not to Med/Surg benefits. *Your* coverage for MH/SUD benefits and Med/Surg benefits must be subject to substantially the same limitations. *Your* ability to access *your* MH/SUD benefits and Med/Surg benefits must be subject to substantially similar conditions.

In general, *your* plan cannot impose any of the following: (a) higher *copayments* and *deductibles* for MH/SUD compared to Med/Surg; (b) greater limits on the number of visits for MH/SUD, compared to Med/Surg; and (c) prior authorization requirements for MH/SUD that are more restrictive than those for Med/Surg.